RKD

01-0428-033

LEONARD JONES JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a,27 per me G792 2/13/01 yf

Certificate of Death

Reg. No. 2001 03001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Leonard Atress Jones	JANUARY 25, 2001	3:30P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
14800 4th STREET	LAUREL	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-98-1902	1☒M 2☐F	37 Yrs.			12-29-1963	Md

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4222 Colborne Road	21229	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12th grade	2 years	Self Employed	Moving Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Leonard O. Jones, Sr	Emma Rose

19a. Informent's Name/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Leonard O. Jones, Sr - Father	4222 Colborne Road Baltimore, Md 21229

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒Buriel 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	Loudon Park Cemetery	2-2-01	Baltimore, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Thomas A. Thompson	March F/H West 4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in deeth)
e. PULMONARY THROMBOEMBOLISM AND HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that Initieted events resulting in deeth) Lest
b.

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Wes case referred to medical exeminer?	26. Piece of Deeth (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Menner of Deeth	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be delermined		M	1☐Yes 2☐No	

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.
2☒ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
▶ Theodore M. Kenny MD	O.C.M.E.	JANUARY 26, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. Kenny 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrer's Signeture
FEB 0 5 2001	Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03002

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GWENDOLYN FISHER JONES
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 8;22PM
4a. Facility Name (If not institution, give street and number): Genesis Homewood
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-10-9392
6. Sex: 1☐ M 2☒ F (XX)
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 14, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☐ No (XX)
10e. Street and Number: 3939 Roland Avenue
10f. Zip Code: 21211
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced (XX)
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No (XX) If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No (XX) Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Presser
16b. Kind of Business/Industry: Cleaning

17. Father's Name (First, Middle, Last): Horace Fisher
18. Mother's Name (First, Middle, Maiden Surname): Olive Minnick

19a. Informant's Name/Relationship (Type, Print): Diane M. Reid GrDTR
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13908 Fox Land Run Phoenix, Md 21131

20a. Method of Disposition: 1☐ Burial 2☒ Cremation (XX) 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery
Date: 2/2/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Dennis Stephen Kenaley
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Failure to Thrive	weeks
Due to (or as a consequence of):	Stroke	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Lung Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: by Attendina
29c. License number: D17118
29d. Date signed (Month, Day, Year): Feb 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz MD 7700 York Rd 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: by B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03003

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia M. Johnson
2. Date of Death: Month January Day 30 Year 2001
3. Time of Death: 02:37
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-22-6913
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 11, 1924
9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Hancock
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13436 Orchard Ridge Road
10f. Zip Code: 21750
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Clarence Smith
18. Mother's Name (First, Middle, Maiden Surname): Gertrude Belle Cosner

19a. Informant's Name/Relationship (Type, Print): Carson Johnson, Sr./Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13436 Orchard Ridge Road Hancock, MD 21750

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Stone Bridge Cemetery
Date: 02/02/01
20c. Location - City or Town, State: Hancock, MD 21750

21. Signature of Funeral Service Licensee: Richard L. Grove
22. Name and Address of Facility: Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Dehydration	days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Rapid Atrial Fibrillation	10 days
Due to (or as a consequence of):		
c.	Coronary Artery Disease	years
Due to (or as a consequence of):		
d.	Hypertension	years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr. Ciccarelli
29c. License number: MD0052136
29d. Date signed (Month, Day, Year): January 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Ciccarelli 3 Byrkit Drive Williamsport Maryland

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: Renee G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Virginia Johnson
Division of Vital Records, P.O. Box 68760,

01-0484-510
mnmr
Eric King

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23a,27,&28a-f per ME G792 021401 SS

Certificate of Death

Reg. No. 2001 03004

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eric W King

2. Date of Death: Month January Day 29, Year 2001

3. Time of Death: 1207 pm

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216 06 2023

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 23 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 7 1977

9. Birthplace (State or Foreign Country): Balto.

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2727 Moorgate Road

10f. Zip Code: 21222

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Roofer

16b. Kind of Business/Industry: Roofer

17. Father's Name (First, Middle, Last): Kenneth W. King

18. Mother's Name (First, Middle, Maiden Surname): Jacqueline M. Blum

19a. Informant's Name/Relationship (Type, Print): Jacqueline M March (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2727 Moorgate Rd, Baltimore, MD 21222

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park | Date: Feb 2

20c. Location - City or Town, State: Elkridge,MD

21. Signature of Funeral Service Licensee: ▶ Dean C Chavis

22. Name and Address of Facility: Chavis Funeral Home 2007 Eastern Ave, Baltimore,MD 21231

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined

28a. Date of Injury (Month, Day Year): found: 1-28-01

28b. Time of Injury: found: unknown M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): house

28f. Location (Street and Number or Rural Route Number, City or Town, State): 1208 Eutaw Place, Balt, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J. Lakon Locke, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): January 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LAKON LOCKE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03005

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
GENEVIEVE MARY SCHUTTE KAISS	January 29, 2001	11:00 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GENESIS ELDERCARE-CROMWELL CENTER	Baynesville	Baltimore County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-01-7403	1☐M 2☒F	82 Yrs.			Nov 5, 1918	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore City	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5926 Glenkirk Road	21239	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th		Homemaker	Own Residence

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Schutte	Anna Mary King

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. James E. Kaiss (Husband)	5926 Glenkirk Road, Baltimore, MD 21239

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Dulaney Valley Mem Grdns	2/1/2001	Timonium, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Martin D. Lawson Martin D. Lawson	Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Biliary obstruction	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Mass - unknown cytology.	
	c.	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Rachelle Gajadhar MD	D0056705	1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RACHELLE GAJADHAR 3007 E. NORTHERN PKWY, BALTIMORE MD 21214

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 05 2001	▶ Bonnie B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03006

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARRIE M. KING
2. Date of Death: Month JAN Day 31 Year 2001
3. Time of Death: 9:55 A.M.
4a. Facility Name (If not institution, give street and number): 1050 W. Saratoga Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 548-18-2309
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/11/20
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1050 W Saratoga St.
10f. Zip Code: 21223
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): Unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): William Rogers
18. Mother's Name (First, Middle, Maiden Surname): Maggie Page

19a. Informant's Name/Relationship (Type, Print): Chris Heidelberg, son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3229 Westmont Ave. Balto. MD 21216

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): Western Star
Date: 2/6/01
20c. Location - City or Town, State: Balto., MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Irvin Carroll Funeral Home 1712 W. Baltimore Ave. Balto Ave. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Cancer Lung

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Stroke

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sankaran
29c. License number: D21649
29d. Date signed (Month, Day, Year): Feb 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMBANDAM BASKARAN 3455 Wilkens Ave. Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: ▶ D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item#1 perPHYG791 2/5/2001 EW
Amended Item#30 perDVRG791 1/31/2001 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03007

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LATOUF George George Latouf
2. Date of Death: Month 01 Day 25 Year 01
3. Time of Death: 5:30AM
4a. Facility Name (If not institution, give street and number): Mariner Health Southern Maryland
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 024-18-2699
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07-10-23
9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9211 Stuart Lane
10f. Zip Code: 20735
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? unk — 1 ☐ Yes 2 ☐ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) — 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. — Specify: white

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): unk — College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Mariner Health Southern Md
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9211 Stuart Lane Clinton, MD 20735

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place) — Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Massive hemoptysis	12hr
Due to (or as a consequence of): b.	Lung Cancer	11 Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one):
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD Attending
29c. License number: D-24535
29d. Date signed (Month, Day, Year): 01.25.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LAXMI N BERWA 7700 Old Branch AVE Clinton, Md 20735

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: Geneva B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03008

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LEILA M. LEE
2. Date of Death Month Day Year: January 26, 2001
3. Time of Death: 5:00pm
4a. Facility Name *(If not institution, give street and number)*: Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-36-6053
6. Sex: 1☐M 2☑F
7. Age *(In yrs. last birthday)*: 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 11-29-1939
9. Birthplace *(State or Foreign Country)*: SC

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: CATONSVILLE
10d. Inside City Limits: 1☐Yes 2☑No
10e. Street and Number: 1015 HANDY AVENUE
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No *Specify:*
14. Rece - American Indian, Bleck, White, etc. *Specify:* BLACK

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12TH GRADE | College (1-4or 5+): 6 YRS
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TEACHER
16b. Kind of Business/Industry: EDUCATION

17. Father's Name *(First, Middle, Last)*: PAUL SMITH
18. Mother's Name *(First, Middle, Maiden Surneme)*: DOROTHY JOHNSON

19a. Interment's Name/Relationship *(Type, Print)*: DONALD LEE | HUSBAND
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 1015 HANDY AVE., BALTO. MD. 21228

20a. Methed of Disposition: 1☑Burial 2☐Cremetion 3☐Removel from Stete 4☐Donation 5☐Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: LOUDON PARK
Date: 02-01-01
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C [illegible]
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO.-NATL' PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one cause on eech line.

		Approximete Interval Between Onset end Death
Immediate Cause (Final diseese or condition resulting in deeth) a.	CVA with cerebral edema and brainstem herniation	2 days
Due to (or as a consequence of): b.		
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or es a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Piece of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: ▶ [illegible] M.D.
29c. License number: D52197
29d. Date signed *(Month, Dey, Year)*: 01-29-2001

30. Nama and address of person who completed ceuse of deeth (Item 23a) (Type, Print): REKHA MOTAGI GBMC 6701 N. CHARLES ST. BALTIMORE, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 05 2001
32. Registrer's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Lee, Lei A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03009

Physician /Medical Examiner

1. Decadant's Name (First, Middle, Last): MARY COLEMAN
2. Dete of Deeth: Month 2 Dey 3 Yaer 2001
3. Time of Deth: 11:30 Pm
4a. Facility Name (If not institution, give street and number): LOREN Nursing Home
4b. City, Town, or Location of Daath: Balto.
4c. County of Death: N.A

Funeral Director

5. Social Security Numbar: 215-22-0223
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Yeer): 12/24/09
9. Birthplece (State or Foreign Country): Md.

Usuel Residence of Decedent

10a. Stete: Md.
10b. County: N.A
10c. City, Town or Location: Balto
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 1718 N. Broadway
10f. Zip Code: 21213
10g. Citizen of Whet Country? U.S.A

11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaer or Datas:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Amarican Indian, Bleck, White, etc. Specify: BLACK

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: self

17. Fether's Name (First, Middle, Lest): HENRY MELLO
18. Mother's Neme (First, Middle, Meiden Surneme): NELLIE WATKINS

19a. Informant's Neme/Reletionship (Type, Print): HENRY MELLO
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2414 ALBION AVE Balto. Md 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Remaval from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Md. National Mem. PK
Dete: 2/7/01
20c. Location - City or Town, State: LAUREL, Md

21. Signeture of Funerel Service Licensea: Joseph H. Locke Jr
22. Name end Address of Facility: Joseph H. Locke Jr F/H. 1304 N. Central Ave

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)
a. CONGESTIVE HEART FAILURE — DAYS

Due to (or es e consequence of):
b. CRITICAL AORTIC STENOSIS — YRS

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c.

Dua to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
DM II c NEUROPATHY · ADVANCED
ATHEROSCLEROSIS.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveileble prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Piece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted.
29b. Signetura and title of certifier: MD.
29c. License number: 041291
29d. Dete signed (Month, Day, Yeer): Jan. 5, 2001
30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): JONATHAN GLAZER, MD. 216 ROSSWOODS DR. # 330 OWINGS MILLS 21117

State Registrar

31. Data filed (Month, Dey, Yeer): FEB 05 2001
32. Registrar's Signeture: Jennifer P. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

2001 JAN 36 AM 1:12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03010

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pauline Logan
2. Dete of Death: Month 1 Dey 31 Yeer 01
3. Time of Deeth: 9:48 AM
4e. Fecility Neme (If not institution, give street and number): Villa St. Michael
4b. City, Town, or Location of Deeth: Baltimore City, Md. 21215
4c. County of Deeth: Baltimore City

Funeral Director

5. Sociel Security Number: 217-01-5006
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 86 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 07-11-1914
9. Birthplece (Stete or Foreign Country): S.C.

Usuel Residence of Decedent

10e. Stete: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4206 Norfolk Ave
10f. Zip Code: 21216
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Reca - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): 12th grade
College (1-4or 5+): na
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Education Specialist
16b. Kind of Business/Industry: Balto City Schools

17. Fether's Neme (First, Middle, Last): William Roberts
18. Mother's Neme (First, Middle, Maiden Surname): Eliza Dotson

19e. Informent's Name/Reletionship (Type, Print): William Hutchins-Grandson
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 4206 Norfolk Ave, Baltimore, Md 21216

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or other placa): Arbutus Memorial Park
Dete: 2/6/01
20c. Location - City or Town, Stete: Arbutus, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr.
22. Neme end Address of Fecility: March F/H West, 4300 Wabash Ave, Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. cardiopulmonary arrest
Due to (or as a consequence of):
b. gastric adenocarcinoma
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No
26. Plece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer): N/A
28b. Time of Injury: M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred: N/A
28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify): N/A
28f. Location (Street and Number or Rurel Route Number, City or Town, State): N/A

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and pleca, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Andrew R. Mayer, MD
29c. License number: D30977
29d. Date signed (Month, Dey, Yeer): 1/31/01

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Andrew R Mayrer, 4800 Seton Dr., Baltimore 21215

State Registrar

31. Date filed (Month, Dey, Yeer): FEB 05 2001
32. Registrar's Signeture: Genevieve D. Foster

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ADH
JAMES LEWIS
01-0556-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23a,b &27 per ME G792-022001-38

Certificate of Death

Reg. No. 2001 03011

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
JAMES Lewis			FEBRUARY 1, 2001	1542 P M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
1028 VALLEY STREET	BALTIMORE CITY		N. A	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216 56 5801	1 X M 2 ☐ F	49 Yrs.			4/17/51	Md.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N. A.	Balto.	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1028 VALLEY St	21202	U S. A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		LAborer	Contractor

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WALter Bernard Lewis	maude Turner

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Hattie BROWN	1028 Valley ST Balto. Md 21202

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)	Mt Zion Cem	2/8/01	Landodarne, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Joseph G. Locke Jr	Joseph G. Locke Jr F/H 1304 N. Central Ave

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CIRRHOSIS	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CHRONIC ALCOHOLISM	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown		
	24a. Was an autopsy performed? 1 X Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No	28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) AT SCENE

27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis J Chutkow	OCME	FEBRUARY 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chutkow 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 05 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03012

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BRIAN LEAHEY

2. Date of Death Month Day Year: JANUARY 28 2001

3. Time of Death: 11:14 PM

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 213 62 4413

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9-12-52

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: 4116 Eder Road, Dundalk, MD 21222

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No

10e. Street and Number: 4116 Eder Road

10f. Zip Code: 21222

10g. Citizen of What Country: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): laborer

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Philip Leahey

18. Mother's Name (First, Middle, Maiden Surname): Marion Koch

19a. Informant's Name/Relationship (Type, Print): Gary Leahey Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4116 Eder Road, Dundalk, MD 21222

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify): in state

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore St, Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SPONTANEOUS BACTERIAL PERITONITIS — 2 Weeks

Due to (or as a consequence of):

b. ALCOHOLIC CIRRHOSIS — 4 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David A. Rapko MD

29c. License number: 20313

29d. Date signed (Month, Day, Year): JANUARY 28 2001

30. Name and address of person who completed cause of death (Item 29e) (Type, Print): DAVID RAPKO, MD JOHNS HOPKINS BAYVIEW 4940 EASTERN AVE BALTIMORE MD 21224

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ASO
02-0572-01

SHELVIA J. LANE

1- For State Registrar AMENDED ITEMS# 23,ptII &27 per ME 6/95 SS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03013

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Shelvia	Jean	Lane	FEBRUARY	01	2001	0740 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ANNE ARUNDEL HOSPITAL	ANNAPOLIS	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-38-2697	1☐M 2☒F	59 Yrs.					02-10-1941	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Crownsville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1520 Crownsville Road	21032	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Robinson	Bernice Fick

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dawn Larson / Daughter	102 Foxhound Drive, Glen Burnie MD 21061

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removet from State 4☐Donation 5☐Other (Specify)	Glen Haven Memorial	02-05 2001	Glen Burnie, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Singleton Funeral Home P.A. 1 Second Ave. S.W. Glen Burnie, MD 21061

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE BRONCHO-PNEUMONIA	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PSYCHOSIS

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis J Chutes MD	O.C.M.E	FEBRUARY 02,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chutes 111 Penn Street, Baltimore, Maryland 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 05 2001	▶ Barbara B. Logan

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03014

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George N. Langley
2. Date of Death — Month: February Day: 1 Year: 2001
3. Time of Death: 10:50pm
4a. Facility Name *(If not institution, give street and number)*: SINAI HOSPITAL of BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-20-2362
6. Sex: 1 ☑ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 6, 1930
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Dacedent

10a. Stete: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 3506 Springdale Avenue
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1 ☑ Yes 2 ☐ No — If Yes, Giva Yeer or Dates: 1947-50
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes 2 ☑ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highast grada completed)* — Elementary/Secondary (0-12): 11th — College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Longshoreman
16b. Kind of Business/Industry: Int'l Longshoremen Ass'n
17. Father's Neme *(First, Middle, Last)*: Nathan Langley
18. Mother's Name *(First, Middle, Maiden Surname)*: Lula Langley
19a. Informant's Name/Relationship *(Type, Print)*: Marlon Langley / WIFE
19b. Malling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3506 Springdale Ave, Balt., MD 21216
20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest V.A.
Dete: 2/7/2001
20c. Location - City or Town, State: Owings Mills, MD
21. Signetura of Funeral Service Licensee ▶
22. Neme end Address of Facility: Hari P. Close Funeral Service, P.A. 709 Tessier St., Balt., MD 21201-1925

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the moda of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximeta Interval Between Onset and Deeth

Immediate Cause (Final disaesa or condition resulting in death)
e. InTracerebral Hemorrhage
Due to (or es a consequence of):
Sequentially list conditions, if any, feeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. HyperTension
Due to (or es a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other afgnificant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Dfd tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to complation of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)* — Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residenca 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, streat, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)* — 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ PHYSICIAN
29c. License number: D0054558
29d. Date signed *(Month, Dey, Year)*: February 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FREDERICK BURK, JR, M.D. 2041 W. Belvedere Ave Baltimore, MD 21215

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 05 2001
32. Registrar's Signatura ▶

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

LANGLEY, GEORGE

CPS
01-0499-025
KATHY MCCALL AMENDED ITEM# 20b per fh G793 030601 SS
AMENDED ITEMS# 23&27 per ME G793 030601 SS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03015

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kathy Ann McCall
2. Date of Death (Month, Day, Year): January 30, 2001
3. Time of Death: 9:00 am
4a. Facility Name (If not institution, give street and number): 1727 DEARWOOD COURT
4b. City, Town, or Location of Death: EDGEWOOD
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 216-80-6716
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 40 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 23, 1960
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Edgewood
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1727 Dearwood Court
10f. Zip Code: 21040
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurses Aide
16b. Kind of Business/Industry: Private Duty

17. Father's Name (First, Middle, Last): Earl Bellamy, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Emma lee Kelly

19a. Informant's Name/Relationship (Type, Print): Emma Bellamy /Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2825 Lodge Farm Road Apt. 326 Edgemere, Maryland 21219

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park
Date: 2-3-2001 ~~2-3-3001~~
20c. Location - City or Town, State: Arbutus, Maryland

21. Signature of Funeral Service Licensee: ▶ Gary Harris
22. Name and Address of Facility: Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE INFARCT OF BRAIN WITH COMPLICATIONS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Theodore M. Kenny
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. Kenny 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 0 5 2001
32. Registrar's Signature: ▶ G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03016

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VERNON ALVIN McCAIN
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 12:30PM M
4a. Facility Name (If not institution, give street and number): 2001 Bluemount Road
4b. City, Town, or Location of Death: Monkton
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 429-54-9042
8. Sex: 1 ☐ M 2 ☐ F XX
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 22, 1934
9. Birthplace (State or Foreign Country): Arkansas

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Monkton
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No XX
10e. Street and Number: 2001 Bluemount Road
10f. Zip Code: 21111
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Caterer
16b. Kind of Business/Industry: Catering/Food

17. Father's Name (First, Middle, Last): Chester Thomas McCain
18. Mother's Name (First, Middle, Maiden Surname): Agnes Beactric Thompson

19a. Informant's Name/Relationship (Type, Print): Kim Goldsmith McCain Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2001 Bluemount Road Monkton Maryland 21111

20a. Method of Disposition: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Hereford Baptist Ch.Cem.
Date: 2/3/01
20c. Location - City or Town, State: Hereford, Maryland

21. Signature of Funeral Service Licensee: Dennis L. Weaks
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute MI
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. CAD
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
3 MI's in the past
S/P PTCAO Stem~~t~~ 1½ yrs.ago

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home XX 5 Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): XX 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D-04461
29d. Date signed (Month, Day, Year): February 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Miriam L. Cohen M.D. 200 East 33rd Street Baltimore Md 21218

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03017

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jessie Miller
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 2:30 PM
4a. Facility Name (If not institution, give street and number): Mallard Bay Nursing Home
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 220-50-8488
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 21 1903
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Madison
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1243 Old Madison Road
10f. Zip Code: 21648
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5 | College (1-4or 5+): Ø
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Walter Landon
18. Mother's Name (First, Middle, Maiden Surname): Amanda Green

19a. Informant's Name/Relationship (Type, Print): Ernest Miller/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1243 Old Madison Road, Madison, MD 21648

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ivy Hill Cemetery
Date: 2/5/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: [signature] M00773
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CONGESTIVE HEART FAILURE — 1 YEAR

Due to (or as a consequence of):
b. GENERALIZED ATHEROSCLEROSIS — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Michael A. Moskowicz MD
29c. License number: D-16609
29d. Date signed (Month, Day, Year): January 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL A. MOSKOWICZ MD. 503 BYRN ST. CAMBRIDGE MD

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: [signature]

2613

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

01-0477-510
mnmr
Mable Morris

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03018

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MABEL MORRIS
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 2030 pm
4a. Facility Name (If not institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-34-0756
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 17, 1935
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/a
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3808 FERNHILL AVE
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerical Worker
16b. Kind of Business/Industry: Social Security Administration

17. Father's Name (First, Middle, Last): CLEO YOUNG
18. Mother's Name (First, Middle, Maiden Surname): ROSELLA BRUCE YOUNG

19a. Informant's Name/Relationship (Type/Print): ERNEST MORRIS / HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3808 FERNHILL AVE BALTIMORE, MARYLAND 21215

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GREENMOUNT CEMETERY
Date: 2/3/01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Jerry Harris
22. Name and Address of Facility: CHATMAN-HARRIS FUNERAL HOME 5240 REISTERSTOWN ROAD BALTIMORE, MARYLAND 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: History of Breast Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? Inspection 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chute
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03019

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KENNETH PARROTT MURPHY

2. Date of Death: Month 02 Day 02 Year 01

3. Time of Death: 10:00 AM

4a. Facility Name (If not institution, give street and number): LONG GREEN NURSING HOME

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 244 08 0165

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 28, 1937

9. Birthplace (State or Foreign Country): N. Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: BALTIMORE

10c. City, Town or Location: WOODLAWN

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4535 MARYKNOLL ROAD

10f. Zip Code: 21207

10g. Citizen of What Country? USA

11. Meritel Stetus: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Raca - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent'a Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 6th grade

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): LABOVER

16b. Kind of Business/Industry: Baltimore Association for Retarded Citizens

17. Father'a Name (First, Middle, Last): HUBERT J. MURPHY

18. Mother's Name (First, Middle, Maiden Surname): RASMA LAURA KARNEGAY

19a. Informant's Name/Relationship (Type, Print): Joseph F. Anastasio / Care giver

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7215 York Road Baltimore, Maryland 21212-1552

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cemetery

Date: 1-07-01

20c. Location - City or Town, State: Dundalk, Maryland

21. Signeture of Funerel Service Licensee: Jerry Harris

22. Name end Address of Facility: CHA Thad - Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — Days

Due to (or as a consequenca of): Stroke — Weeks

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. Due to (or es a consequenca of):

c. Due to (or es a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underiying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated.

29b. Signature and title of certifier:

29c. License number: D17118

29d. Date signed (Month, Day, Year): Feb 2, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Paul Schwartz MD 7700 York Rd 21204

State Registrar

31. Dete filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signeture: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

2001 JAN 35 PM 10:46

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03020

NORRIS, ALMIRA 02-03-01 2:20A

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner | **Funeral Director** | **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Almira	Jean	Norris	February 3, 2001	2:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilcrest Nursing Center	Towson	Baltimore

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213 68 9549	1☐M 2☒F	45 Yrs.			May 7, 1955	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Belcamp	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1210 Mistwood Court Unit 202	21017	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Claim Adjuster	Social Security Admin.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Norris	Genevieve C. Gray

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Geoerge Norris Sr. (father)	2210 Monocacy Road Baltimore, Maryland 21221

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crametory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Holly Hill Mem. Gardens	2/6/2001	Baltimore County, Md

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Bruzdzinski Funeral Home PA
1407 Old Eastern Avenue Essex, Maryland 21221

Physician /Medical Examiner | **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Adenocarcinoma of the colon	1 year
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ W. Anthony Riley, MD	D25205	February 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W.A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 0 5 2001	[signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03021

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAXINE Scott Nelson
2. Date of Death: Month JANUARY Day 30 Year 2001
3. Time of Death: 15:43
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 189-32-1277
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 19, 1938
9. Birthplace (State or Foreign Country): NorthAmpton NC

Usual Residence of Decedent

10a. State: PA
10b. County: DELAWARE
10c. City, Town or Location: MARCUS HOOK
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1039 Green st APPT B
10f. Zip Code: 19061
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN Home

17. Father's Name (First, Middle, Last): Scott ADAMS SR
18. Mother's Name (First, Middle, Maiden Surname): Martha Jarrell

19a. Informant's Name/Relationship (Type, Print): Carlon Nelson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 923 Hillside Ave Boothwyn PA 19061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Cedarwood Cem
Date: Feb 2 2001
20c. Location - City or Town, State: ROANOKE RAPIDS NC

21. Signature of Funeral Service Licensee: ▶ Gary L. Rollins
22. Name and Address of Facility: South st HEDRICK, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE
Due to (or as a consequence of):
b. OBSTRUCTIVE PNEUMONIA
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. LUNG CANCER
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ CWS MD
29c. License number: D0023533
29d. Date signed (Month, Day, Year): JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES N. SCHOENFELD, M.D. 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: ▶ Jeanne D. Landa

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03022

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WANDA PAZDAN
2. Date of Death (Month, Day, Year): January 25, 2001
3. Time of Death: 6:00 A.M.
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MED. CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-05-2949
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 23, 1914
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 940 S. LAKEWOOD AVE. APT. 112
10f. Zip Code: 21224
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 4 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): WALTER SZYMANSKI
18. Mother's Name (First, Middle, Meiden Surname): ROSALIE ANDREASIK

19a. Informant's Name/Relationship (Type, Print): EDWARD PAZDAN
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7811 SCHOLAR RD. DUNDALK, MD. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS CEM. Date: JAN 27 2001
20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.
22. Name and Address of Facility: SKARDA F.H. 2829 HUDSON ST. BALTO. MD. 21224

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis	7 days
Due to (or as a consequence of): b.	Urinary tract infection	1 month
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Pneumonia	7 days
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary artery disease, Atrial fibrillation, Cerebrovascular accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D54962
29d. Date signed (Month, Day, Year): January 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Wells, MD, 3501 Sinclair, Baltimore, Maryland, 21213

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 03023

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DANIEL PARKER
2. Date of Death Month: FEBRUARY Day: 1 Year: 2001
3. Time of Death: 1:12 PM
4a. Facility Name *(If not Institution, give street and number)*: JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 579-72-1333
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 48 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12-30-52
9. Birthplace *(State or Foreign Country)*: PA.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4509 Belair Road
10f. Zip Code: 21206
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): 4yrs.
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self-employed
16b. Kind of Business/Industry: Bar

17. Father's Name *(First, Middle, Last)*: Daniel Ellsworth Parker, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Fort

19a. Informant's Name/Relationship *(Type, Print)*: Thomas Barbara Williams+Annie
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 607 Forrester Street Washington, DC 20032

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Greenmount Cemetery — Date: 2-5-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Gladys Wanner
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CIRRHOSIS — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Kenneth Bilchick, MD
29c. License number: RES 000
29d. Date signed *(Month, Day, Year)*: FEBRUARY 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KENNETH BILCHICK TOWER 110 - JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21287

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 05 2001
32. Registrar's Signature: Lenore B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03024

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Alma Parker
2. Date of Death (Month, Day, Year): February 4 2001
3. Time of Death: 12:25 AM
4a. Facility Name (If not institution, give street and number): Riverview Nursing Solutions
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 227-34-1367
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 28 1930
9. Birthplace (State or Foreign Country): Boonesville, VA.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1 Eastern Avenue
10f. Zip Code: 21221
10g. Citizen of What Country?: U.S. of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Receptionist
16b. Kind of Business/Industry: McCormick Company

17. Father's Name (First, Middle, Last): Robert E. Shiflett
18. Mother's Name (First, Middle, Maiden Surname): Jennie Mary Hall

19a. Informant's Name/Relationship (Type, Print): Michael G. Bailey (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 102 Monoponosan Road, Stevensville, Maryland 21666

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Prize Hill Cemetery | Date: February 6,2001
20c. Location - City or Town, State: Boonesville, Virginia

21. Signature of Funeral Service Licensee: Mark Chojnacki
22. Name and Address of Facility: W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. COPD
Due to (or es e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia; GI bleed

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, end due to the cause(s) and mennar stated.
29b. Signature end title of certifier: Nancy K. Bailowitz M.D.
29c. License number: D47573
29d. Date signed (Month, Dey, Year): February 4,2001
30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print): Nancy Bailowitz M.D. 5601 Loch Raven Blvd. Russell Morgan Bldg 3rd Fl. Baltmo 21239

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: Geneva B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

01-0525-025
crn
Rodney S. Parish

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03025

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Rodney S. Parish	January 31, 2001	6:50 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Harford Memorial Hospital	Havre de Grace	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
161-56-2917	1☒M 2☐F	37 Yrs.			7-14-1963	Pa

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
N.J.	Gloucester	Sewell	1☐Yes 2☒No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24 Derby Drive	08080	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	N/A	Nuclear Technician	P.E.C.O. Energy

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Lee Chamber	JOANNE LEOLA PARISH

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Deborah Parish - Wife	24 Derby Drive Sewell, N. J. 08080

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Fernwood Cemetery	2-8-01	Fernwood, Pa 19050

21. Signature of Funeral Service Licensee: ▶ Jerome A Thompson

22. Name and Address of Facility: March F/H. West, 4300 Wabash Avenue Baltimore, Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Spinal Cord injury	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? X☐Yes 2☐No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1-31-2001	6:00 AM	1☐Yes 2☒No	Subject was driver involved in a collision

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street

28f. Location (Street and Number or Rural Route Number, City or Town, State): Glen Cove/Castleton Darlington, Maryland

29a. Certifier (Check only one) 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Stephen S. Radentz, M.D.	O.C.M.E.	February 01, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date Filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03026

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
EMORY	LEE	PARKS	FEBRUARY 2, 2001	5:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3224 TARTARIAN COURT	LANSDOWNE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-26-5998	1☒ M 2☐ F	72 Yrs.			JAN. 24, 1929	VIRGINIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	BALTIMORE	LANSDOWNE	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
3224 TARTARIAN COURT	21227	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
8		TOW MOTOR OPERATOR	APPLIANCE MANUFACTURER

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Meiden Surname)		
EMORY	CLAYTON	PARKS	EMMA	EDELL	MITCHELL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
MRS. MILDRED PARKS (WIFE)	3224 TARTARIAN COURT, LANSDOWNE, MD. 21227

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece) Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	GLEN HAVEN MEMORIAL PARK 02/06/2001	GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee ▶ D Marzolf M00795

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

e. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted avents resulting in death) Last

b. Hypertensive and Atherosclerotic Heart Disease 486

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the pest 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Descnbe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ Certifying Phyaician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated. 2☐ Medical Examinar: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶ Colvin Clarke, MD	D0 14 59	Feb. 2, 2001

30. Neme end address of person who completed cause of death (Item 28a) (Type, Print)

4710 Pennington Avenue Baltimore, Maryland 21226

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
FEB 05 2001	▶ Brenda D. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 7 PER F.H. G792 2-5-01 WR:

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03027

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Keiasia Richardson

2. Date of Death: Month: January Day: 31 Year: 2001

3. Time of Death: 1014 AM

4a. Facility Name (If not institution, give street and number): 4625 TALMAN RD.

4b. City, Town, or Location of Death: PIKESVILLE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-55-9178

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 1 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): MAR 17, 1999

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD. | 10b. County: BALTIMORE | 10c. City, Town or Location: PIKESVILLE | 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4625 TALMAN RD. | 10f. Zip Code: 21208 | 10g. Citizen of What Country? U.S.A

11. Meritel Stetus: 1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 0 | College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): ALTON RICHARDSON

18. Mother's Neme (First, Middle, Maiden Surname): LAKEISHA SNUGGS

19a. Informent's Name/Relationship (Type, Print): LAURA SNUGGS

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4625 TALMAN RD. PIKESVILLE MD. 21208

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☒ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): KING MEMORIAL | Date: 2/5/01

20c. Location - City or Town, Stete: RANDALLSTOWN MD.

21. Signature of Funeral Service Licensee: [signature]

22. Neme and Address of Facility: GARRETT-MARCH FUNERAL HOME P.A. 2710 FREDERICK PIKE BALTIMORE MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset end Death
Immediete Cause (Finel diseese or condition resulting in death) a.	cerebral Palsy	16 months
Due to (or es e consequence of): b.	Hydrocephalus	16 months
Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es a consequence of): c.	Congenital absence of cerebellum	16 months
Due to (or es a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, etreet, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and piece, end due to the cause(s) end menner as stated. 2☒ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: [signature] MD Deputy

29c. License number: D18667

29d. Dete signed (Month, Day, Year): February 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PHILIP Militello, MD Shock Trauma 22 S. Greene ST. Baltimore, Md 21201

State Registrar

31. Dete filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item # 18, per FH, 2/5/2001 G292 *Certificate of Death* Reg. No. 2001 03028

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Helen	Robinson	02 / 01 / 2001	6:00a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manor Care Nursing Home	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
403-18-1849	1☐M 2☒F	102 Yrs.			05 15 1898	K.Y.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4669 Falls Road	21209	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	na	Day Care Counselor	City Of Baltimore

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname) ~~Unknown~~
Unknown	Amanda Ketchum

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Tia Gordon-Great Niece	6406 Kriel Street, Baltimore Md 21207

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Arbutus Memorial Park 2/3/01	Arbutus, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John B. Johnson	March F/H West 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Dementia	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Anemia	
	Due to (or as a consequence of): c. Femur Fracture	
	Due to (or as a consequence of): d. Degenerative Joint Disease	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D 31464	2/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHOAIB A. HASHMI, 821 N. Eutaw St Route 308 Balt MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 05 2001	Donna B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03029

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRY A. SVRJCEK
2. Date of Death (Month, Day, Year): JAN. 31, 2001
3. Time of Death: 2:15 P.M.
4a. Facility Name (If not institution, give street and number): 1826 BRIARCLIFF ROAD
4b. City, Town, or Location of Death: LOCH RAVEN HEIGHTS
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-07-0025
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/21/1921
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: LOCH RAVEN HEIGHTS
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1826 BRIARCLIFF ROAD
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2 YEARS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONTRACT ADMINISTRATOR
16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Father's Name (First, Middle, Last): JAMES SVRJCEK
18. Mother's Name (First, Middle, Maiden Surname): MARY FRESHLINE

19a. Informant's Name/Relationship (Type, Print): DOROTHY G. SVRJCEK WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1826 BRIARCLIFF ROAD BALTIMORE, MD 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MORELAND MEMORIAL PARK — Date: 2/3/01
20c. Location - City or Town, State: HILLENDALE, MD

21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic esophageal cancer	~1½ yrs.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Paul Chang, MD
29c. License number: D16587
29d. Date signed (Month, Day, Year): 2/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Chang, M.D. 5601 Loch Raven Blvd, Ste 107, Baltimore, MD 21239

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per fh 1/7/01 2/13/01 yf

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

For State Registrar

Reg. No. 2001 03030

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EMMA TURNER
2. Date of Death Month Day Year: 01-30-2001
3. Time of Death: 4:40 P M
4a. Facility Name (If not institution, give street and number): CATONSVILLE COMMONS
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212 07 9184
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 7, July 11, 1911
9. Birthplace (State or Foreign Country): 1911 Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1333 Brook Road
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Wessley Evans
18. Mother's Name (First, Middle, Maiden Surname): Mary Carroll

19a. Informant's Name/Relationship (Type, Print): David B, Turner / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 April Court Windsor Mill, MD. 21244

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery Date: 2/5/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature] Melois
22. Name and Address of Facility: Vaughn Greene Funeral Home 5151 Balto. Nat'l Pike Balto., MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. HCVD — Approximate Interval Between Onset and Death: Yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. HTN — Due to (or as a consequence of): — Yrs.
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: S/P CVA; Atrial fibrillation

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Attending MD
29c. License number: D 36942
29d. Date signed (Month, Day, Year): January 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B JURAKHIA, MD. 1009 Frederick Rd. Catonsville, MD 21228

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03031

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DIANE C. TAYLOR
2. Date of Death (Month, Dey, Year): January 25, 2001
3. Time of Death: 2217
4a. Facility Name (If not institution, give street and number): UNION MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-64-0174
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 46 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03-05-1954
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 3814 BONVIEW AVENUE
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12TH GRADE
College (1-4or 5+): 2 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STAFF COORDINATOR
16b. Kind of Business/Industry: HEALTH CARE

17. Father's Name (First, Middle, Last): HORACE BURROUGHS
18. Mother's Name (First, Middle, Maiden Surname): MEGALELINE WRIGHT

19a. Informant's Name/Relationship (Type, Print): THOMAS TAYLOR | HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3814 BONVIEW AVE., BALTO. MD. 21213

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY
Date: 2-3-01
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C [illegible]
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NAT'L PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. cerebral infarction — 20 hours
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Interstitial pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [illegible], MD.
29c. License number: AT 2438946
29d. Date signed (Month, Day, Year): January 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Deborah WATSON, M.D. Union Memorial Hospital 201 E. University Parkway, Baltimore, MD 21218

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: ▶ [illegible]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03032

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRANCIS W. TUEL

2. Date of Death Month: JAN. Day: 30 Year: 2001

3. Time of Death: 7:40PM

4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice

4b. City, Town, or Location of Death: Baltimore County

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-01-5765

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 11, 1917

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 6106 Shady Spring Avenue

10f. Zip Code: 21237

10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WW 11

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 7 yrs.

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Store Room Keeper

16b. Kind of Business/Industry: City of Baltimore

17. Father's Name *(First, Middle, Last)*: John Herbert Tuel, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Theresa A. Linthicum

19a. Informant's Name/Relationship *(Type, Print)*: Margaret Moreland

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6106 Shady Spring Avenue Baltimore, Md. 21237

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lorraine Park Cemetery

Date: 2-2-01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Ronald C. Lassahn

22. Name and Address of Facility: Lassahn Funeral Home 7401 belair Rd. Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Malignant Melanoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* Hospice

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D43725

29d. Date signed *(Month, Day, Year)*: 1/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ MAHMOOD 201-109 Backriver neck Rd Baltimore MD 21221

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signature: Denise G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 8 PER F.H. G792 2-5-01 WR.

Certificate of Death

Reg. No. 2001 03033

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN GRACE TAYLOR
2. Date of Death: Month January, Day 28, Year 2001
3. Time of Death: 4:23 PM
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217 40 0602
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 10/03 ~~Oct 13~~, 1944
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3443 PARKHEIGHTS AVE
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEKEEPER
16b. Kind of Business/Industry: Hotel

17. Father's Name (First, Middle, Last): WILLIAM J. TAYLOR
18. Mother's Name (First, Middle, Maiden Surname): CLARA LEE

19a. Informant's Name/Relationship (Type, Print): KIM TERRELL DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215: 2855 W. Coldspring Lane Baltimore, Md

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 2-2-2001
20c. Location - City or Town, State: BALTIMORE, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: CHATHAM - HARRIS Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatic failure — 5 years
Due to (or as a consequence of):
b. GI BLEED
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alcohol abuse

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Malka Blass, MD
29c. License number: RES000
29d. Date signed (Month, Day, Year): January 28, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Malka Blass, MD 2401 West Belvedere Avenue Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Evelyn Taylor
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0452-510
jhm
LAWRENCE A
WILLIAMS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#18perFHG792 2/21/2001 EW

Certificate of Death

Reg. No. 2001 03034

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAWRENCE A. WILLIAMS
2. Date of Death: Month JANUARY Day 27 Year 2001
3. Time of Death: 00:10 AM
4a. Facility Name (If not institution, give street and number): 5012 DENVIEW AVENUE APARTMENT D
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-46-0276
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-05-1946
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 5012 DENVIEW AVE. #D
10f. Zip Code: 21206
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 TH GRADE; College (1-4or 5+): 2 YRS
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): CAB DRIVER
16b. Kind of Business/Industry: TRANSPORTATION

17. Father's Neme (First, Middle, Last): PAUL WILLIAMS
18. Mother's Name (First, Middle, Meiden Surneme): Alma V. ~~ELMA~~ DORSEY

19a. Informent's Neme/Relationship (Type, Print): PAULETTE BOLDEN | DAUGHTER
19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3801 BARRINGTON RD., BALTO. MD. 21215

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): GARRISON FOREST
Dete: 2-2-01
20c. Location - City or Town, Stete: OWINGS MILLS, MD

21. Signature of Funerel Service Licensee: ▶ Daughn C H
22. Neme end Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused tha daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in deeth): a. Atherosclerotic Cardiovascular Disease

Due to (or es a consequence of):

Sequentielly iist conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of causa of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE
27. Manner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner steted.

29b. Signature and title of certifier: ▶ Dennis Clutter
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 27, 2001

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): Dennis Clutter 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED ITEM# 5 per fh G792 02/06/01 SS

Reg. No. 2001 03035

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jennifer Hitchcock Whittington

2. Date of Death Month: JANUARY Day: 30 Year: 2001

3. Time of Death: 24:00

4a. Facility Name (If not institution, give street and number): Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 219-44-8722

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09 27 46

9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3999 Whispering Meadow Drive

10f. Zip Code: 21133

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+): 5yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Asst. Vice President

16b. Kind of Business/Industry: MD Nat. Bank

17. Father's Name (First, Middle, Last): Alvin Paul Jones

18. Mother's Name (First, Middle, Maiden Surname): Jewel Oglesby

19a. Informant's Name/Relationship (Type, Print): Norman Whittington Sr-Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3999 Whispering Meadow Drive, Randallstown Md 21133

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park

Data: 2/6/01

20c. Location - City or Town, State: Arbutus, Md

21. Signature of Funeral Service Licensee: ▶ [signature] B. Burke

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILATION CAUSING AN EMBOLUS TO THE LEFT LOWER EXTREMITY RESULTING IN MUSCLE NECROSIS AND SOURCE OF SEPSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ BARROCAS, MD

29c. License number: RES 000

29d. Date signed (Month, Day, Year): JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. Barrocas M.D. 2401 West Belvedere Ave Baltimore M.D. 21215

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: ▶ [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

WHITTINGTON, JENNIFER

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha Wilkinson Young

2. Date of Death (Month, Day, Year): February 2, 2001

3. Time of Death: 8:45 am

4a. Facility Name (If not institution, give street and number): 5821 Queens Chapel Road

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-05-8822

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 24 1914

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5821 Queens Chapel Road

10f. Zip Code: 20782

10g. Citizen of What Country? USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Edcetion (Specify only highest grade completed)

Elementery/Secondary (0-12): 12

College (1-4or 5+): Ø

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): Thomas A. Wilkinson, Sr.

18. Mother's Neme (First, Middle, Maiden Surneme): Bertha Holden

19a. Informant's Name/Relationship (Type, Print): Thomas E. Dyer/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9005 Horton Road, Laurel, MD 20708-2805

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem.

Date: 2/9/01

20c. Location - City or Town, Stete: Arlington, VA

21. Signature of Funeral Service Licensee: Janice A Parks M01103

22. Neme end Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): e. Myocardial Infarction — Immediate

Due to (or es e consequence of): CAD

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d.

Pert II. **Other signiflcent conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.: Alzheimers Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bruce Greenberg

29c. License number: RES-0000

29d. Dete signed (Month, Day, Year): 02/02/2001

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Bruce Greenburg 6825 16th Street, NW Washington, DC 20012

State Registrar

31. Dete filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03037

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BENNIE LEO BOND

2. Date of Death Month / Day / Year: JANUARY 20, 2001

3. Time of Death: 2:40 AM

4a. Facility Name *(If not institution, give street and number)*: GLADYS SPELLMAN NURSING HOME

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 215-14-7567

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG. 3, 1915

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGES

10c. City, Town or Location: CHEVERLY

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2900 MERCY LANE

10f. Zip Code: 20785

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7TH GRADE — College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER

16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name *(First, Middle, Last)*: JOHN HENRY BOND

18. Mother's Name *(First, Middle, Maiden Surname)*: ALICE HUNGERFORD BOND

19a. Informant's Name/Relationship *(Type, Print)*: LELIA T. HICKS / SISTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5650 WASHINGTON AVENUE, LA PLATA, MARYLAND 20646

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SACRED HEART CHURCH CEM.

Date: 1/26/01

20c. Location - City or Town, State: LA PLATA, MARYLAND

21. Signature of Funeral Service Licensee: LYDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Diabetes — M-Year

Due to (or as a consequence of):

b. CVA (Cardiovascular Accident) — M-Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension — M-Years

Due to (or as a consequence of):

d. Decubitus ulcer — Days-Months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Depression

Sepsis, osteoporosis, osteomylitis

Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D

29c. License number: D0056184

29d. Date signed *(Month, Day, Year)*: 01.22.2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JALAL SAIED, M.D. 3001 Hospital Dr., Cheverly, MD 20785

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: Jennie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0378-033
CHARLES BATCH
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM 23a,27,28a-f per ME G794 041701 SS

Certificate of Death

Reg. No. 2001 03038

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLES WILLIAM BATCH
2. Date of Death Month Day Year: JANUARY 22 2001
3. Time of Death: 1649
4e. Facility Name *(If not institution, give street and number)*: SOUTHERN MARYLAND HOSPITAL
4b. City, Town, or Location of Death: CLINTON
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 217-64-8793
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEB 7 1955
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8703 Dangerfield Road
10f. Zip Code: 20735
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer
16b. Kind of Business/Industry: Glass instalation

17. Fether's Name *(First, Middle, Last)*: Joseph E. Batch Sr
18. Mother's Name *(First, Middle, Meiden Surneme)*: Barbara Ann Tessier Batch

19e. Informent's Neme/Reletionship *(Type, Print)*: Maureen A. Batch (Sister)
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 36915 Kimberly Court Mechanicsville, MD 20659

20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Metropolitan Crematory
Dete: 1-25-01
20c. Location - City or Town, Stete: Alexandria, VA

21. Signature of Funeral Service Licensee: John A. Eber M00173
22. Name and Address of Feciility: Eberwein Funeral Services 4433 White Pls. La. White Pls., MD 20695

Physician Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediete Cause (Final diseese or condition resulting in death)
a. HEAD INJURIES WITH COMPLICATIONS
Due to (or as e consequenca of):
b.
Due to (or es e consequenca of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the ceuse of death? 1 [ ] Yee 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed? 1 [X] Yes 2 [ ] No
24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Piece of Deeth *(Check only one)*: Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Menner of Death: 1 [ ] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28e. Dete of Injury *(Month, Dey Year)*: 1-22-01
28b. Time of Injury: 1:30 A M
28c. Injury et Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject repeatedly struck with baseball bat
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: other residence
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*: 15607 Brandywine Rd. Brandywine, MD

29e. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner es steted. 2 [X] **Medical Examiner**: On the besis of exemineticn end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: Theodore M. King MD
29c. License number: O.C.M.E
29d. Dete signed *(Month, Day, Year)*: JANUARY 23, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 25 2001
32. Registrer's Signature: Penne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03039

Expired 1-22-01 @ 3:00pm

Dr. Anderson

Clawson, Florence # 997528

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FLORENCE MAE CLAWSON
2. Date of Death — Month: JANUARY; Day: 22; Year: 2001
3. Time of Death: 3:00 PM
4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital Center
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 201-12-3479
8. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs.
If Under 1 Year: Months; Days
If Under 24 Hrs.: Hours; Min.
8. Date of Birth *(Month, Day, Year)*: NOV 20 1916
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12021 Livingston Road
10f. Zip Code: 20744
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse
16b. Kind of Business/Industry: Health Care
17. Father's Name *(First, Middle, Last)*: John E. Work
18. Mother's Name *(First, Middle, Maiden Surname)*: Lima Hetrick Work
19a. Informant's Name/Relationship *(Type, Print)*: Kay E. Work (daughter in law)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 658 Currant Court La Plata, MD 20646
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 1-26-01
20c. Location - City or Town, State: Alexandria, VA
21. Signature of Funeral Service Licensee: John H. Eberwein M00173
22. Name and Address of Facility: Eberwein Funeral Services, 4433 White Pls. La. White Pls., MD 20695

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. COPD (Chronic Obstructive Pulmonary Disease)

Due to (or as a consequence of):
b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Ventricular Arrythmias

Due to (or as a consequence of):
d. Pulmonary Hypertension

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D41182
29d. Date signed *(Month, Day, Year)*: 1-24-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Felton Anderson MD 11418 Livingston Rd Ft. Washington, MD 20744

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03040

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Naomi Marie Stanley Cooper
2. Dete of Deeth — Month: 01 Day: 22 Year: 01
3. Time of Death: 12:15P
4a. Facility Name *(If not institution, give street end number)*: Mallard Bay Care Center
4b. City, Town, or Location of Death: Cambridge
4c. County of Deeth: Dorchester

Funeral Director

5. Socisl Security Number: 214-07-8792
6. Sex: 1☐M 2☑F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: February 2, 1916
9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: Bayly Crossing - 1117 High Street
10f. Zip Code: 21613
10g. Citizen of Whet Country?: USA

11. Merital Status: 1☐Never Married 2☐Married 3☑Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1☐Yes 2☑No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐Yes 2☑No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Crab Picker
16b. Kind of Business/Industry: Seafood Industry

17. Fether's Neme *(First, Middle, Last)*: Hanson Stanley
18. Mothar's Neme *(First, Middle, Maiden Sumame)*: Julia Nichols

19a. Informant's Neme/Reletionship *(Type, Print)*: William Cornish
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1117 High St. Bayly Crossing Cambridge, Maryland 21613

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Garrison Forest St. Vet. Cemetery — Date: 1/29/2001
20c. Location *(City or Town, Stete)*: Owings Mills, Maryland

21. Signeture of Funeral Service Licensee: Janelle C. Henry
22. Neme end Address of Facility: Henry Funeral Home P.A. 510 Washington St. Cambridge, Maryland 21613

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one ceuse on eech line. — Approximete Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in deeth):
a. Cardiac Arrhythymia — 4 min
Due to (or es a consequence of):
b. Chronic Debilitated State — 3 yrs
Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Disaesa or injury thet initieted events resulting in death) Last
Due to (or es a consequence of):
c. Renal Insufficency — 3 yrs
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24e. Wes an eutopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☑Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Mennar of Death: 1☑Natural 2☐Accident 3☐Suicida 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how Injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To tha best of my knowledge, death occurred et the time, date and piece, and due to tha causa(s) and manner as stated. 2☐**Medical Examiner:** On tha basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) end mennar steted.

29b. Signeture and title of certifier: Michael Fackler MD
29c. License number: D26388
29d. Dete signed *(Month, Day, Year)*: Jan 23, 2001

30. Neme and address of person who completed causa of deeth (Item 23a) (Type, Print): Michael Fackler MD 302 Collins, Hurlock MD 21643

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signeture: Jeanne G. Lewis

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03041

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marva R. Daily

2. Date of Death — Month: Jan; Day: 17; Year: 2001

3. Time of Death: 2350

4a. Facility Name *(If not institution, give street and number)*: 1017 Powhattan Blvd.

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 217-28-4297

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Aug 12, 1935

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1017 Powhattan Blvd.

10f. Zip Code: 21801

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: William J. Batson

18. Mother's Name *(First, Middle, Maiden Surname)*: Viola Mitchell

19a. Informant's Name/Relationship *(Type, Print)*: Roswald T. Daily/husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1017 Powhattan Blvd., Salisbury, MD 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Springhill Memory Gardens

Date: 1/23/2001

20c. Location - City or Town, State: Hebron, MD

21. Signature of Funeral [illegible]

22. Name and Address of Facility: Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. ASCVD

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

↑Cholesterol

HTN

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury:

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signature and Title of certifier: D.O. DME

29c. License number: H50497

29d. Date signed *(Month, Day, Year)*: 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 106 Milford St. #201 Salisbury MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signeture: [illegible]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03042

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nellie K. Dantoni

2. Date of Death (Month, Day, Year): JANUARY 26, 2001

3. Time of Death: 2:31 PM

4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 408-28-4306

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 24, 1922

9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 956 H. Hillswood Rd.

10f. Zip Code: 21014

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Hooker Harden

18. Mother's Name (First, Middle, Maiden Surname): Ellen Easter

19a. Informant's Name/Relationship (Type, Print): Thomas E. Dantoni / spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 956 H. Hillswood Rd. Bel Air, MD. 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Cemetery

Date: Jan. 30 2001

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Harry H. witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CARDIAC ARREST - ASYSTOLIE	1 HOUR
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	RESPIRATORY ARREST	3 HOURS
Due to (or as a consequence of):		
c.	CORONARY ARTERY DISEASE STENT	24 HOURS
Due to (or as a consequence of):		
d.	MYOCARDIAL INFARCTION	2 DAYS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D35453

29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LINDA BARR, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Dantoni, Nellie

(10)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 03043

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Willow Grace Dickinson
2. Date of Death: Month January Day 23 Year 2001
3. Time of Death: 0805
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-32-3696
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 24, 1935
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 13426 Windsor Dr.
10f. Zip Code: 21742
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elemantary/Secondary (0-12): 12; College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Health Care Industry

17. Father's Name (First, Middle, Last): Worthington Kline
18. Mother's Name (First, Middle, Maiden Surnama): Blanche Suder

19a. Informant's Name/Relationship (Type, Print): John M. Dickinson, Sr. / spouse
19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code): 13426 Windsor Dr. Hagerstown, MD 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery
Date: 1/25/01
20c. Location - City or Town, Stata: Hagerstown, MD

21. Signature of Funeral Service Licensee: Lloyd M Mag
22. Name and Address of Facility: Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that causad tha death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	Respiratory Failure	2 weeks
Due to (or as a consequenca of): b.	Congestive Heart Failure	10 years
Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Cardiomyopathy	15years
d.		

Part ff. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.: Diabetes Mellitus -type II

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☒ No
26. Place of Death (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Data of injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner stated.

29b. Signature and title of certifier: Joan Newman Ph.D. MD
29c. License number: D 17591
29d. Date signed (Month, Day, Year): 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Newman 11110 Medical Campus Rd. Hag. Md. 21742

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CPS
01-0535-013
RACHEL FERGUSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23a&27 per ME G792 02/01/01

Certificate of Death

Reg. No. 2001 03011

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RACHEL ELYSE FERGUSON
2. Date of Death Month Day Year: February 1, 2001
3. Time of Death: 4:45 AM
4a. Facility Name (If not institution, give street and number): CARROLL COUNTY GENERAL
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 213-43-3230
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 6 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yaar): Sep 5, 1994
9. Birthplace (State or Foraign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐Yas 2☒No
10e. Street and Number: 3807 Rinehart Rd.
10f. Zip Coda: 21158
10g. Citizen of Whet Country?: USA
11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yas 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐Yas 2☒No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White
15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): Kindergarten; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): Student
18b. Kind of Businass/Industry: Carroll Christian School
17. Father's Name (First, Middle, Last): Eric Vane Ferguson
18. Mothar's Nama (First, Middla, Maiden Surneme): June A. Clisso
19a. Informant's Name/Relationship (Type, Print): M/M Eric Ferguson Parents
19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code): 3807 Rinehart Rd. Westminster, MD 21158
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Nama of cematary, crematory or othar placa): Pipe Creek Cem.
Data: Feb 3 2001
20c. Location - City or Town, Stata: Uniontown, MD
21. Signature of Funeral Service Licensee: John K Ayres
22. Nama and Addrass of Facility: Pritts Funeral Home and Chapel, P.A. 412 Washington Rd. Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach line.

Approximata Intarval Batwaen Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDITIS

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequenca of):
c. Due to (or as a consequance of):
d. Due to (or as a consequance of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcoma of pregnancy 1☐Liva birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pregnent at tima of daath 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23a. Did tobacco use contributa to tha causa of daath? 1☐Yes 2☒No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☒Yas 2☐No
24b. Were autopsy findings available prior to completion of causa of death? 1☒Yas 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒Yes 2☐No
28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Othar: 4☐Nursing Home 5☐Residence 8☐Othar (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify)
28f. Location (Straat and Numbar or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To tha bast of my knowledga, daath occurrad at the tima, data and place, and dua to tha cause(s) and mennar as stated. 2☒ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, deeth occurred at the time, data and placa, and dua to tha causa(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. Licensa number: OCME
29d. Date signad (Month, Day, Yaar): February 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 28e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03045

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clarence Pierce Fox

2. Date of Death (Month, Day, Year): January 20 2001

3. Time of Death: 7:10 am

4a. Facility Name *(If not institution, give street and number)*: Wicomico Nursing Home

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 207-14-9808

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 6 1925

9. Birthplace *(State or Foreign Country)*: Delaware

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 27901 Nanticoke Road

10f. Zip Code: 21801

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: vice-president/cashier

16b. Kind of Business/Industry: banking

17. Father's Name *(First, Middle, Last)*: Clarence John Fox

18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah Walraven

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Fox - wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 27901 Nanticoke Rd., Salisbury, MD 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dorchester Memorial Park

Date: 1-22

20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: Kenneth R Thomas Jr.

22. Name and Address of Facility: Thomas Funeral Home, PA
700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. respiratory failure

Due to (or as a consequence of): Ramsay Hunt Syndrome

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Scott Rifkin

29c. License number: D34145

29d. Date signed *(Month, Day, Year)*: January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Rifkin, M.D. 11 Aston Court, Owings Mills, MD 21117

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03046

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary K. Favorite

2. Date of Death (Month, Day, Year): Jan. 12 2001

3. Time of Death: 1:45 A.M.

4a. Facility Name (If not institution, give street and number): Magnolia Gardens Nursing Center

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577 40 1217

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 25, 1930

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 3518 Maureen Lane

10f. Zip Code: 20715

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edward Flaherty

18. Mother's Name (First, Middle, Maiden Surname): Edith Windland

19a. Informant's Name/Relationship (Type, Print): Richard L. Favorite Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3518 Maureen Lane Bowie Maryland 20715

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery | Date: Jan. 16, 2001

20c. Location - City or Town, State: Clinton Maryland

21. Signature of Funeral Service Licensee: ▶ Michael L. Bagley

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — 5minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: 047603

29d. Date signed (Month, Day, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William DuBoyce, MD 4000 Mitchellville Rd B216 Bowie, MD 20716

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

6

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: pening ▶ B. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03047

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARK J GREENFIELD
2. Date of Death: Month JAN Day 29 Year 2001
3. Time of Death: 6:40PM
4a. Facility Name (If not institution, give street end number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 214 17 3101
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 24 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 23, 1976
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 3208 Cornnell Lane
10f. Zip Code: 21042
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled
16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): B. James Greenfield
18. Mother's Name (First, Middle, Maiden Surname): Sheila Cross

19a. Informant's Name/Relationship (Type, Print): B. James Greenfield/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6420 Autumn Sky Way Columbia, MD 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Columbia Memorial Park | Date: 2-2-2001
20c. Location - City or Town, State: Clarksville, MD

21. Signature of Funeral Service Licensee: Shona Collins-Witzke MOD044
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or comptications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. SEPTIC SHOCK — 0 DAYS
Due to (or as a consequence of):
b. PNEUMONIA — 0 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
THROMBOCYTOPENIA
SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: F Chvidian MD
29c. License number: 042892
29d. Date signed (Month, Day, Year): JAN 29 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS CHVIDIAN MD 10724 LITTLE PATUXENT PKWY COLUMBIA MD 21044

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(12)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03048

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Archie J. Grogan

2. Date of Death Month / Day / Year: January 30, 2001

3. Time of Death: 6:40pm

4a. Facility Name *(If not institution, give street and number)*: 1022 10th Street

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-20-2111

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 25, 1923

9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1022 10th Street

10f. Zip Code: 20707

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1947

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Contractor

16b. Kind of Business/Industry: Home Improvements

17. Father's Name *(First, Middle, Last)*: Robert Grogan

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha M. Akers

19a. Informant's Name/Relationship *(Type, Print)*: Michael Grogan/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1005 Turney Avenue, Laurel, MD 20707

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD Veterans Cemetery

Date: 2/2/01

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: Louis Donaldson M00160

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Hepatic Failure — 2 1/2 Years

Due to (or as a consequence of):
b. Idiopathic Hepatitis — 2 1/2 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Drug Induced Hepatitis

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 36822

29d. Date signed *(Month, Day, Year)*: 1/31/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DAVID CROSSEN MD 2415 Musgrove Road, #307, Silver Spring, MD 20904

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: Bernice G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Dad

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03049

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marta Louise Holt

2. Date of Death (Month, Day, Year): January 17, 2001

3. Time of Death: 2350

4a. Facility Name *(If not institution, give street and number)*: Peninsula Regional Medical Center

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 226-82-6526

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 14, 1953

9. Birthplace *(State or Foreign Country)*: Washington

Usual Residence of Decedent

10a. State: Virginia

10b. County: Accomack

10c. City, Town or Location: Chincoteague

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6449 Vacation Park Lane

10f. Zip Code: 23336

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Registered Nurse

16b. Kind of Business/Industry: Sibley Memorial Hospital

17. Father's Name *(First, Middle, Last)*: Elmer Dean Holt

18. Mother's Name *(First, Middle, Maiden Surname)*: Joan Colladay Barrett

19a. Informant's Name/Relationship *(Type, Print)*: Adrienne Clayton Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8305 Southern Oaks Court, Lorton, Virginia 22079

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Occohannock Crematory

Date: 1-19-01

20c. Location - City or Town, State: Exmore, Virginia

21. Signature of Funeral Service Licensee: Constance Salyer Cobb Bailey

22. Name and Address of Facility: Salyer Funeral Home Chincoteague, Virginia 23336

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ANOXIC ENCEPHALOPATHY — 10 d

Due to (or as a consequence of):
b. SEVERE HYPOGLYCEMIA — 10 d

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul R Fleury MD

29c. License number: 024872

29d. Date signed *(Month, Day, Year)*: 1/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL FLEURY 305 TENTH ST POCOMOKE CITY MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 2 2 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

17 DA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03050

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN HINES
2. Date of Death: Month JANUARY Day 28 Year 2001
3. Time of Death: 13:27
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE City
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-12-5571
6. Sex: 1☐M 2☐F — X
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 14, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Howard
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐Yes 2☐No — XX
10e. Street and Number: 10752 Scaggsville Road
10f. Zip Code: 20723
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sheet Metal Mechanic
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): John L. Hines
18. Mother's Name (First, Middle, Maiden Surname): Sarah Margaret Leishear

19a. Informant's Name/Relationship (Type, Print): Ida E. Hines / spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10752 Scaggsville Road Laurel, Maryland 20723

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Emmanuel Church Cemetery
Date: Feb. 1, 2001
20c. Location - City or Town, State: Scaggsville, Maryland

21. Signature of Funeral Service Licensee: [signature] / M00770
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CORONARY ARTERY DISEASE — 25 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: FULMINANT HEPATIC FAILURE; ACUTE RENAL FAILURE; MESENTERIC ISCHEMIA

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): JANUARY 28 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL HOUSE MD THE JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST. BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03051

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MADELINE HUTTER
2. Date of Death Month Day Year: 01 - 26 - 01
3. Time of Death: 10:25AM
4a. Facility Name (If not institution, give street and number): LAUREL REGIONAL HOSPITAL
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-20-7389
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 04-22-21
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9157 Grant Avenue
10f. Zip Code: 20723
10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Counselor
16b. Kind of Business/Industry: District Government

17. Father's Name (First, Middle, Last): Adolphus Gottlieb Hutter
18. Mother's Name (First, Middle, Maiden Surname): Mary Louise Keller

19a. Informant's Name/Relationship (Type, Print): Joan Weatherholtz/ Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10184 Owen Brown Road Columbia, MD 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rosedale Cemetery
Date: 1/30/01
20c. Location - City or Town, State: West Virginia

21. Signature of Funeral Service Licensee: ▶ [signature] MO1213
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, MD 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE ANTERIOR MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION
CONGESTIVE HEART FAILURE
RENAL FAILURE.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Abdul Nayeem M.D.
29c. License number: D.21294
29d. Date signed (Month, Day, Year): 01-26-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABDUL NAYEEM, M.D. 3450-FORT MEADE ROAD, SUITE 100, LAUREL M-D. 20724

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10 dod

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03052

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Catherine Kramer

2. Date of Death Month: January Day: 21, Year: 2001

3. Time of Death: 3:00PM

4a. Facility Name (If not institution, give street and number): 5729 Mt. Holly Road

4b. City, Town, or Location of Death: East New Market

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 220-32-1460

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 29, 1910

9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: Maryland

10b. County: Dorchester

10c. City, Town or Location: East New Market

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5729 Mt. Holly Road

10f. Zip Code: 21631

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Adolf Thomsen

18. Mother's Name (First, Middle, Maiden Surname): Catherine Martens

19a. Informant's Name/Relationship (Type, Print): John J. Kramer/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5725 Mt. Holly Road, East New Market, MD 21631

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): East New Market Cemetery

Date: 1/24/01

20c. Location - City or Town, State: East New Market, MD

21. Signature of Funeral Service Licensee: Leonard O. Zeller

22. Name and Address of Facility: Zeller Funeral Home, P. O. Box 207, 106 Main Street, East New Market, MD 21631

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Arrhythmia	4 min
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Generalized Debilitation	10 yrs
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Osteoporosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Faulkner MD

29c. License number: D26388

29d. Date signed (Month, Day, Year): JAN 22, 2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Michael Faulkner MD 302 Collins, Hurlock MD 21643

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03053

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Allan C. Lynch, Sr.

2. Date of Death — Month: JANUARY Day: 17 Year: 2001

3. Time of Death: 0007

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 222-10-5433

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Jan. 12, 1919

9. Birthplace *(State or Foreign Country)*: Delaware

Usual Residence of Decedent

10a. State: DE

10b. County: Kent

10c. City, Town or Location: Milford

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 453 Frontage Rd.

10f. Zip Code: 19963

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner & Operator

16b. Kind of Business/Industry: Clothing Store

17. Father's Name *(First, Middle, Last)*: Alfred L. Lynch

18. Mother's Name *(First, Middle, Maiden Surname)*: Jennie Payne

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Lynch - wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 453 Frontage Rd., Milford, DE 19963

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Odd Fellows Cemetery

Date: 1-20-01

20c. Location - City or Town, State: Milford, DE

21. Signature of Funeral Service Licensee: George M Short

22. Name and Address of Facility: Berry-Short Funeral Home 119 NW Front St., Milford, DE 19963

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Asphyxia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Respiratory Congestive Heart Failure

Due to (or as a consequence of):

c. Ischemic Cardiomyopathy

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Clayton L. Raab MD

29c. License number: D19289

29d. Date signed *(Month, Day, Year)*: 1-17-2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 400 Eastern Shore Dr Salisbury MD 21801 / Clayton L. Raab MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

ALLAN LYNCH SS# 222-10-5433 1/17/01 0007 Age 81 Jan 1

11+1VA DQ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03054

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Harry Leonard

2. Date of Death (Month, Day, Year): January 24, 2001

3. Time of Death: 8:45 PM

4a. Facility Name (If not institution, give street and number): St. Mary's Nursing Center

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 413-10-7171

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 22, 1914

9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Leonardtown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 22680 Cedar Lane Court #1329

10f. Zip Code: 20650

10g. Citizen of What Country? U S A

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Insurance

17. Father's Name (First, Middle, Last): W.A. Leonard

18. Mother's Name (First, Middle, Maiden Surname): Margaret Lewis

19a. Informant's Name/Relationship (Type, Print): Donna G. Leonard (Grandaughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20619: 45297 Mill Cove Harbor Rd., California, Maryland

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Brinsfield-Echols

Date: 1/25/01

20c. Location - City or Town, State: Charlotte Hall, Maryland

21. Signature of Funeral Service Licensee: Mary Rizzo M01114

22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Failure to thrive — Few weeks

Due to (or as a consequence of):
b. Institutional Neglect — long time

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. Organic brain Syndrom — long time

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A.D. Shah

29c. License number: D 47068

29d. Date signed (Month, Day, Year): 1-25-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.D. Shah, MD Leonardtown, Maryland 20650

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ST MARY'S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 4a per Phy.
01/23/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03055

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jean Elizabeth Miller

2. Date of Death (Month, Day, Year): Jan. 18, 2001

3. Time of Death: 11:05AM

4a. Facility Name (If not institution, give street and number): ~~3921 Turkeyfoot Road~~ ~~Carroll County General Hospital~~

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 218-38-4143

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 3, 1929

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 3921 Turkeyfoot Road

10f. Zip Code: 21158

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Arthur Maxwell Martin

18. Mother's Name (First, Middle, Maiden Surname): Sylvia Josephine Loupp

19a. Informant's Name/Relationship (Type, Print): Lynda Bauerlien/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 206 Davis Lane Westminster, MD 21157

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Mem. Gardens | Date: 01/22/2001

20c. Location - City or Town, State: Finksburg, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Pritts Funeral Home & Chapel, P.A. 412 Washington Rd. Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. chronic obstructive pulmonary disease

Due to (or as a consequence of):
b. Multiple Sclerosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CAD
HTN

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D51705

29d. Date signed (Month, Day, Year): 1-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. PANSURIYA, 419F Malcolm DR, Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03056

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Philip R. Meekins

2. Date of Death (Month, Day, Year): January 22 2001

3. Time of Death: 10:34 AM

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 212-20-8988

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 8 1925

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 9933 Middle Mill Drive

10f. Zip Code: 21117

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yes 2☐ No. If Yes, Give Yaar or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant

16b. Kind of Business/Industry: Self-employed

17. Fathar's Name (First, Middla, Last): David I. Meekins

18. Mother's Name (First, Middle, Maiden Surname): Hilda E. Hickey

19a. Informant's Neme/Relationship (Type, Print): Helen Meekins Wife

19b. Mailing Address (Street end Number or Rural Route Numbar, City or Town, Stete, Zip Code): 9933 Middle Mill Drive Owings Mills, MD 21117

20a. Method of Disposition: 1☐ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Mausoleum

Date: Jan. 25,

20c. Location - City or Town, Stata: 2001 Sykesville, MD

21. Signature of Funeral Service Licensee: Jana B Conuy

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Sykesville, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications thet ceusad the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. acute myocardial infarction — unknown

Due to (or as a consequence of):

b. atherosclerotic cardiovascular disease — unknown

Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the causs of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piace, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Jon Falck MD

29c. License number: D47353

29d. Date signed (Month, Day, Year): Janury 22, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Jon Falck MD St. Agnes Hospital 900 Caton Avenue Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

PHILIP MEEKINS

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0523-013
B.K.S

PATRICK A. MOLLOY
AMEND# 23&27 per ME G793 030901 SS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03057

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patrick A. Molloy

2. Date of Death (Month, Day, Year): JAN. 30, 2001

3. Time of Death: 2208 PM

4a. Facility Name (If not institution, give street and number): CARROLL COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: WESTMINTER

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 217-58-1068

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 2 1953

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: New Windsor

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4019 Franklinville Road

10f. Zip Code: 21776

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Auto Mechanic

16b. Kind of Business/Industry: Smiths Service Center

17. Father's Name (First, Middle, Last): Davies Warfield Molloy

18. Mother's Name (First, Middle, Maiden Surname): Rose Mary Leonard

19a. Informant's Name/Relationship (Type, Print): Jo Ann E. Molloy Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4019 Franklinville Road New Windsor, MD 21776

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Pine Grove Cemetery

Date: Feb. 3,

20c. Location - City or Town, State: 2001 Mt. Airy, MD

21. Signature of Funeral Service Licensee: Jane B Cory

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart taitura. List only ona causa on each line.

Approximate Intarval Batween Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequanca of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Ware autopsy findings available prior to completion of ceuse of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only ona)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residenca 8☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be detarmined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☐ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date end place, and dua to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On tha basis of examination and/or investigation, In *my* opinion, death occurred at tha tima, data and place, and due to tha cause(s) and manner stated.

29b. Signature end title of certifier: Theodore McKinney MD

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): JAN. 31, 2001

30. Nama and addrass of person who comptated causa of death (Item 23a) (Type, Print): THEODORE McKinney 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03058

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Francis Martin

2. Date of Death (Month, Day, Year): January 17 2001

3. Time of Death: 8:50AM

4a. Facility Name *(If not institution, give street and number)*: College View Nursing Center

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 238-24-5625

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 3, 1922

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Virginia

10b. County: Fairfax

10c. City, Town or Location: McLean

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 977 Spencer Rd.

10f. Zip Code: 22102

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: confectioner

16b. Kind of Business/Industry: candy manufacturing

17. Father's Name *(First, Middle, Last)*: William Henry Martin

18. Mother's Name *(First, Middle, Maiden Surname)*: Jennie Estelle Sledge

19a. Informant's Name/Relationship *(Type, Print)*: Mildred M. Butt/ sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 977 Spencer Rd. McLean, VA 22102

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Summerfield U.M. Ch.Cemetery | Date: 1/20/01

20c. Location - City or Town, State: Summerfield, NC

21. Signature of Funeral Service Licensee: Catharine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home P.O. Box 249 New Windsor, MD 21776

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Heart failure

Due to (or as a consequence of):
b. Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Dementia

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pt was NO code, H/O Skin cancer H/O pneumonia.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Mohiuddin

29c. License number: D39458

29d. Date signed *(Month, Day, Year)*: 1-17-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sabiha H. Mohiuddin 801 Toll House Ave. Frederick, MD 21701

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03059

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN PITTARD McILVAINE
2. Date of Death (Month, Day, Year): January 17 2001
3. Time of Death: 1:05 p.m.
4a. Facility Name (If not institution, give street and number): Wicomico Nursing Home
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 221-34-4249
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 4, 1909
9. Birthplace (State or Foreign Country): FAIRMOUNT, DE

Usual Residence of Decedent

10a. State: MD
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 311 WHITMAN RD.
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): GEORGE DAVID PITTARD
18. Mother's Name (First, Middle, Maiden Surname): EVA BURTON

19a. Informant's Name/Relationship (Type, Print): MARVIN L. McILVAINE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 311 WHITMAN AVE., SALISBURY, MD 21801

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CREMATORY OF DELMARVA
Date: 1-18-01
20c. Location - City or Town, State: DELMAR, DE

21. Signature of Funeral Service Licensee: George M. Short
22. Name and Address of Facility: SHORT FUNERAL SERVICES, 609 E. MARKET ST., GEORGETOWN, DE 19947

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Senile Dementia, Alzheimer's Type — 5 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Arteriosclerotic Cardiovascular Disease
Essential Hypertension, Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Gregorio M. Belloso
29c. License number: D 29505
29d. Date signed (Month, Day, Year): 1-18-2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORIO M. BELLOSO, M.D. - 5302 CHINABERRY DR., SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Helen P McIlvaine

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03060

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gilbert A. Nelson
2. Date of Death (Month, Day, Year): January 17, 2001
3. Time of Death: 3:20PM
4a. Facility Name *(If not institution, give street and number)*: 11727 Fort Washington Road
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-50-4331
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 20, 1940
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11727 Fort Washington Road
10f. Zip Code: 20744
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1960-1963
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Auditor
16b. Kind of Business/Industry: Federal Government
17. Father's Name *(First, Middle, Last)*: William Nelson
18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth B. Davis
19a. Informant's Name/Relationship *(Type, Print)*: Sandra A. McCall/ Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Same as item 10
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory | Date: 1/21/01
20c. Location - City or Town, State: Alexandria, Virginia
21. Signature of Funeral Service Licensee: George P. Kalas Jr.
22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Amyotrophic Lateral Sclerosis — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D00037529
29d. Date signed *(Month, Day, Year)*: 01/18/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. Wheeler, M.D. 1221 Mercantile Lane Largo, Md. 20721

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: D. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03061

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Patton
2. Date of Death (Month, Day, Year): January 22 2001
3. Time of Death: 19:31
4a. Facility Name (If not institution, give street and number): University of Maryland Medical System
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 197-38-8079
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 3, 1947
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Finksburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1723 Fawn Way
10f. Zip Code: 21048
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1966-1971
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Central Office Technician
16b. Kind of Business/Industry: Phone Company

17. Father's Name (First, Middle, Last): Thomas Hamilton Patton
18. Mother's Name (First, Middle, Maiden Surname): Bernice Mae Hartwell

19a. Informant's Name/Relationship (Type, Print): Kathleen W. Patton/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1723 Fawn Way, Finksburg, MD 21048

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville Veteran Cemetery | Date: 1/26/01
20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: Suzanne Flaherty Myers
22. Name and Address of Facility: Myers Funeral Home, 91 Willis Street, Westminster, MD 21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Candidal Fungemia
Due to (or as a consequence of):
b. Disseminated Varicella Zoster Virus
Due to (or as a consequence of):
c. Acute Renal Failure
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anthony Eugene Munson M.D.
29c. License number: P14675
29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 22 South Greene ST. 21201
Anthony Eugene Munson, University of Maryland Medical System, Baltimore, Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

·wj1
Amend Item 4a per Phy. and 19b per F.D. 01/24/2001, Carroll County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03062

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Peter Milton Risty	January 18, 2001	9:45pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
~~6094 Springhill Drive~~ 6904 Springhill Drive	Eldersburg	Carroll County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
334-34-3197	1☒M 2☐F	60 Yrs.			Nov 20, 1940	Illinois

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Carroll	Eldersburg	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6904 Springhill Drive	21784	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5	Computer Manager	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Peter T. Risty	Dorothy Smith

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Sandra Ellyn Risty (Wife)	6904 Springhill Drive, Eldersburg, Maryland 21784 ~~6094 Springhill Drive Eldersburg, MD 21784~~

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	All County Cremation Srv	1/20/01	Sykesville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Brian K. Haight	HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gastric Adenocarcinoma stage IV	10 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Liver failure 2° to tumor, Anemia, Anemia - Cachexia

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Jon K. Winfield MD.	D30573	1-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jon K. Winfield, MD 11065 Little Patuxent Parkway. Columbia, MD 21044

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 24 2001	▶ Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03063

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Margaret Stiegmann
2. Date of Death (Month, Day, Year): JAN 19 2001
3. Time of Death: 7:10 am
4a. Facility Name (If not institution, give street and number): Golden Age Guest Home
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 216-03-5746
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Oct. 10, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2401 Haight Avenue
10f. Zip Code: 21784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Clerical

17. Father's Name (First, Middle, Last): Martin Carr
18. Mothar's Name (First, Middle, Maiden Surname): Mary O'Shea

19a. Informant's Name/Relationship (Type, Print): Mrs. Peggy L. Culleton (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2401 Haight Avenue Sykesville, MD 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Name of cemetery, cramatory or other place): Lorraine Park Cemetery
Data: 1/22/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Brian L. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not enter tha moda of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one ceuse on each line.

Approximata Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. PRIMARY DEGENERATIVE DEMENTIA — > 3 YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. CHRONIC URINARY TRACT INFECTION — > 2 YRS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RHEUMATOID ARTHRITIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yss 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ Patrick Turners MD
29c. Licensa number: D 20806
29d. Date signed (Month, Day, Year): 1/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRICK TURNER MD 1000 LIBERTY RD ELDERSBURG, MD 21784

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03064

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Robert Smarik, Sr.

2. Date of Death Month / Day / Year: 01 / 21 / 2001

3. Time of Death: 12:05 a.m.

4a. Facility Name *(If not institution, give street and number)*: Carroll Lutheran Village

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 363 03 0687

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 17, 1914

9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. State: Md.

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street and Number: 1608 Terrace Drive

10f. Zip Code: 21157

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: 1944-1946 Navy

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Draftsman- Graphics

16b. Kind of Business/Industry: Social Security Admin.

17. Father's Name *(First, Middle, Last)*: John Smarik

18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Bohus

19a. Informent's Name/Relationship *(Type, Print)*: Beverly A. Smarik (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1608 Terrace Dr. Westminster, Md. 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lake View Mem. Park

Date: 1/24/01

20c. Location - City or Town, State: Sykesville, Md.

21. Signature of Funeral Service Licensee: ▶ Harry W. Haight

22. Name and Address of Facility: Haight Funeral Home & Chapel P.O.Box 195 Sykesville, Md. 21784

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

John R. Smarik

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Parkinson's Disease — Six years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Howard G. Lanham M.D.

29c. License number: D17040

29d. Date signed *(Month, Day, Year)*: January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard G. Lanham, M.D. 215 Washington Heights Med'l Ctr, Westminster, MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03065

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marshall Eugene Stottlemyer
2. Date of Death (Month, Day, Year): January 19 2001
3. Time of Death: 4:10PM
4a. Facility Name (If not institution, give street and number): 12443 Detour Rd.
4b. City, Town, or Location of Death: Keymar
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 217-30-5490
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 14, 1935
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Keymar
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12443 Detour Rd.
10f. Zip Code: 21757
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): truck driver
16b. Kind of Business/Industry: soft drink bottling co.

17. Father's Name (First, Middle, Last): Paul Elmer Stottlemyer
18. Mother's Name (First, Middle, Maiden Surname): Nellie Wetzel

19a. Informant's Name/Relationship (Type, Print): Patricia Stottlemyer/ wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12443 Detour Rd. Keymar, MD 21757

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Hill Cemetery
Date: 1/23/01
20c. Location - City or Town, State: Legore, MD

21. Signature of Funeral Service Licensee: ▶ Catharine O. Hartzler
22. Name and Address of Facility: Hartzler Funeral Home 404 S. Main St. Woodsboro, MD 21798

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC NON-SMALL CELL LUNG CANCER — 4 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE PULMINARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
26d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Brian M. O'Connor, MD
29c. License number: D31761
29d. Date signed (Month, Day, Year): 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN M. O'CONNOR MD 501 W. SEVENTH ST. FREDERICK, MD 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03066

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Mary Smith

2. Date of Death: Month: January Day: 21 Year: 2001

3. Time of Death: 4:15AM

4a. Facility Name (If not institution, give street and number): Glade Valley Nursing & Rehabilitation Ctr.

4b. City, Town, or Location of Death: Walkersville

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 578-74-1641

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 18, 1910

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Walkersville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 56 W. Frederick St.

10f. Zip Code: 21793

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): William Fogarty

18. Mother's Name (First, Middle, Maiden Surname): Margaret McGinn

19a. Informant's Name/Relationship (Type, Print): Margaret Tregoning/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1109 Baust Church Rd. Union Bridge, MD 21791

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: 1/24/01

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: Catharine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, 11802 Liberty Rd. Libertytown, MD 21762

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. STROKE — 5 Days

Due to (or as a consequence of):
b. Seizure Disorder — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D43091

29d. Date signed (Month, Day, Year): 1-23-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAEED ZAIDI · 801 TOLL HOUSE Ave, Frederick MD 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03067

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John V. Sullivan
2. Date of Death (Month, Day, Year): January 30 2001
3. Time of Death: 7:45am
4a. Facility Name (If not institution, give street and number): Copper Ridge Nursing Home
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219 18 2847
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 28, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Elkridge
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5802 Bellanca Drive
10f. Zip Code: 21075
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1945-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teamster President
16b. Kind of Business/Industry: Local #355 Union

17. Father's Name (First, Middle, Last): Maurice Sullivan
18. Mother's Name (First, Middle, Maiden Surname): Marie Kearney

19a. Informant's Name/Relationship (Type, Print): Gladys H. Sullivan/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5802 Bellanca Drive Elkridge, Maryland 21075

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Cemetery
Date: 2-2-2001
20c. Location - City or Town, State: Ellicott City, MD

21. Signature of Funeral Service Licensee: Shena Gillmore-Witzke MA044
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — 6 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [✓] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert L. Moss MD
29c. License number: 032082
29d. Date signed (Month, Day, Year): 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Moss 114 Business Cent. Dr. Reisterstown, Md 21136

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Barbara J. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(8)

CJ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03068

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alvern William Scott
2. Date of Death (Month, Day, Year): January 26, 2001
3. Time of Death: 9:00 AM
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 061-05-0924
6. Sex: 1☐ M 2☐ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 9, 1907
9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12113 Ivory Fashion Court
10f. Zip Code: 20708
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): Ø
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mail Handler
16b. Kind of Business/Industry: US Postal Service

17. Father's Name (First, Middle, Last): Henry Scott
18. Mother's Name (First, Middle, Maiden Surname): Annie McKinney

19a. Informant's Name/Relationship (Type, Print): Leverta R. Daughtery/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12113 Ivory Fashion Court, Laurel, MD 20708

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland National Mem.PK
Date: 1/29/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: [signature] M00773
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cancer of the Colon with metastasis
Due to (or as a consequence of):
b. Pneumonia
Due to (or as a consequence of):
c. Severe Anemia
Due to (or as a consequence of):
d. old age

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] John Theobalds
29c. License number: D0023350
29d. Date signed (Month, Day, Year): 1/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John B Theobalds MD 9811 Mallard Drive, Laurel, MD 20708

State Registrar

31. Date filed (Month, Day, Year): 1/29/01 2001
32. Registrar's Signature: [signature] Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 dad

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03069

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Odilia Thomas

2. Date of Death Month Day Year: January 22, 2001

3. Time of Death: 6:30 AM

4e. Facility Name *(If not institution, give street and number)*: Genesis Elder Care Center

4b. City, Town, or Location of Death: La Plata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 578-30-6537

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 26, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Colmar Manor

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3417 39th Place

10f. Zip Code: 20772

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: File Clerk

16b. Kind of Business/Industry: US Federal Government

17. Father's Name *(First, Middle, Last)*: Leo Gruss

18. Mother's Name *(First, Middle, Maiden Surname)*: Hedwig Foehr

19e. Informant's Name/Relationship *(Type, Print)*: Dorothy Mary Smoyer - Niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16400 Tanyard Road, Upper Marlboro, MD 20772

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans' Cemetery

Date: 1-31-01

20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: John P. Knisley M01164

22. Name and Address of Facility: Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ADVANCED ALZHEIMER'S DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ADVANCED DEGENERATIVE JOINT DISEASE

Due to (or as a consequence of):

c. Advanced Atherosclerosis.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D20629

29d. Date signed *(Month, Day, Year)*: 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 11345 Ryon Brooke Sq, Suite 103 Waldorf, Md 20603 George Whitehead

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03070

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Earnest Townsend Sr.

2. Date of Death Month / Day / Year: Jan. 11 2001

3. Time of Death: 9:00 A.M.

4a. Facility Name *(If not institution, give street and number)*: 5911 Rayborn Dr.

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 722-01-7689

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 96 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Dec. 9, 1904

9. Birthplace *(Stata or Foreign Country)*: Scotland Co.N.C.

Usual Residence of Decedant

10a. Stata: North Carolina

10b. County: Richmond Co.

10c. City, Town or Location: Hamlet

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 170 Campbell Road, Rt. 1

10f. Zip Coda: 28345

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decadant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada compliatad)*: Elamentary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Barber

16b. Kind of Business/Industry: Cosmetology

17. Fathar's Name *(First, Middla, Last)*: William Townsend

18. Mother's Neme *(First, Middle, Maiden Sumame)*: Mary Dupree Townsend

19a. Informent's Name/Ralationship *(Type, Print)*: Edward Townsend / Son

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 524 - 68th Street, Seat Pleasant, MD 20743

20a. Mathod of Disposition: 1☒ Buriat 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Mary Love Cemetery

Data: 1/17/01

20c. Location - City or Town, State: Hamlet, N. C.

21. Signature of Funaral Sarvice Licensee: Bernie L Jones II

22. Name and Addrass of Facility: James E. Vann Funeral Home, 4804 Ga. Ave. N. W., Wash., D. C. 20011

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that caused tha daath. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona ceuse on aach lina.

Approximata Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. Failure to Thrive — 6 Months

Dua to (or as a consequance of):

Sequentially list conditions, if any, leeding to immadiata cause. Enter Undarlying Cause (Disease or Injury thet initieted events rasulting in death) Last

b. Anemia — 1 year

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceuse givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wera autopsy findings available prior to completion of ceuse of deeth? 1☐ Yas 2☐ No

25. Wes cesa rafarred to medicel axaminar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Othar *(Specify)* Son Resid

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigetion 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at the time, date end place, and dua to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and mannar stated.

29b. Signatura and title of certifiar

29c. Licansa number: D24093

29d. Data signed *(Month, Day, Year)*: 11/17/01

30. Neme and address of person who complated ceusa of daath (Item 23a) (Type, Print): Mark Parkhurst, MD 7305 Baltimore Ave. College Park, MD 20740

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001

32. Registrar's Signatura: Penny D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03071

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Roland Towers, Sr.

2. Date of Death Month: January Day: 20 Year: 01

3. Time of Death: 10:40a.m.

4a. Facility Name *(If not institution, give street and number)*: Caroline Nursing Home, Inc.

4b. City, Town, or Location of Death: Denton, Maryland

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 212-12-3805

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: December 6, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Denton

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 9224 Andersontown Road

10f. Zip Code: 21629

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Caucasian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 HS Grad | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner/Operator

16b. Kind of Business/Industry: Concrete Products

17. Father's Name *(First, Middle, Last)*: Thomas Houston Towers

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertie Mae Adams

19a. Informent's Name/Relationship *(Type, Print)*: Norma Lee Towers Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9224 Anderstontown Road, Denton, Maryland 21629

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Denton Cemetery

Date: 1/24/01

20c. Location - City or Town, State: Denton, Maryland

21. Signature of Funeral Service Licensee: Randolph P. Moore

22. Name and Address of Facility: Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only* one cause *on* each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. Coronary Artery Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dele and place, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: James Sides MD

29c. License number: D31376

29d. Date signed *(Month, Dey, Year)*: 1-22-01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): James Sides, M.D., PO Box 496, Denton, Maryland 21629

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Joanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03072

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Philip Kannarkat Verghese
2. Data of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 11:15 AM
4a. Facility Name *(If not institution, give street and number)*: 41040 Paw Paw Hollow Lane
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 214-76-7748
6. Sex: 1 ■ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 30 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Sept. 15, 1970
9. Birthplaca *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Leonardtown
10d. Inside City Limits: 1 ☐ Yas 2 ■ No
10e. Street and Number: 41040 Paw Paw Hollow Lane
10f. Zip Code: 20650
10g. Citizan of What Country?: United States

11. Marital Status: 1 ■ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yas 2 ■ No. If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ■ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* Asian Indian

15. Decedant'a Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12): | Collega (1-4or 5+): 5+
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Physician
16b. Kind of Businass/Industry: Medical

17. Fathar's Nama *(First, Middla, Last)*: Kannarkat Pappachan Verghese
18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Annie Phillips

19a. Informant's Name/Ralationship *(Type, Print)*: Kannarkat P. Verghese / Father
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 41040 Paw Paw Hollow Lane, Leonardtown, MD 20650

20a. Mathod of Disposition: 1 ■ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Charles Memorial Gardens
Data: 1-14-01
20c. Location - City or Town, Stata: Leonardtown, Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, JR. M00052
22. Nama and Addrass of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwean Onset and Death

Immediata Causa (Final disaasa or conditlon resulting in daath)
a. Cardiopulmonary Failure — hrs
Due to, or as a consequence of:
b. Acquired Immune Deficiency Syndrome — yrs
Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated avants resulting in daath) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ■ No
24b. Wara autopsy findings available prior to complation of causa of daath? 1 ☐ Yas 2 ☐ No

25. Was casa rafarrad to medical examinar? 1 ☐ Yas 2 ■ No
26. Placa of Death *(Check only ona)*: Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Homa 5 ■ Rasidance 6 ☐ Othar *(Specify)*

27. Mannar of Death: 1 ■ Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding invastigation 6 ☐ Could not be datarmined
28a. Data of Injury *(Month, Day Yaar)* | 28b. Tima of Injury M | 28c. Injury at Work? 1 ☐ Yas 2 ☐ No | 28d. Dascribe how injury occurrad
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1 ■ **Certifying Physician**: To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 ☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.
29b. Signatura and title of cartifiar: James P. Jarboe M.D.
29c. Licansa number: D 0649
29d. Data signed *(Month, Day, Year)*: 1-12-01

30. Nama and addrass of parson who compilated causa of death (Item 23a) (Type, Print): James P. Jarboe, M.D., 24035 Three Notch Road Hollywood, Maryland 20636

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signatura: Laura G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

(3)

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03073

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Earl B. Wootten, Sr.

2. Date of Death (Month, Day, Year): JANUARY 18 2001

3. Time of Death: 2000

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 221-05-9814

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 19, 1903

9. Birthplace (State or Foreign Country): DE.

Usual Residance of Decedent

10a. State: De.

10b. County: Sussex

10c. City, Town or Location: Delmar

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: P.O. Box 27

10f. Zip Code: 19940

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Giva Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Store owner

16b. Kind of Business/Industry: Grocery Store

17. Fathar's Nama (First, Middle, Last): Edward Washington Wootten

18. Mothar's Nama (First, Middla, Maiden Surname): Martha Truitt Wootten

19a. Intormant's Name/Relationship (Type, Print): Mildred Wootten, Wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): P.O. Box 27 Delmar, De. 19940

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, cramatory or other place): St. Stephens Cemetery

Date: 1-23-01

20c. Location - City or Town, State: Delmar, De.

21. Signature of Funeral Service Licensee: William M Short

22. Nama and Address of Facility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one causa on each line.

Approximate Intarval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in daath): a. congestive heart failure

Due to (or as a consequence of):

Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last:

b.

Due to (or as a consequance of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying ceuse givan in Part I.

pneumonitis

anemia

atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings available prior to complation of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding investigation 6 [ ] Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at tha time, data and place, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rodney A. Wenrich M.D

29c. Licanse number: D15384

29d. Data signed (Month, Day, Year): JAN 18, 2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print): RODNEY A. WENRICH 100 POWER STREET SALISBURY MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

EARL WOOTTEN 221-05-9814

6DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03074

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret May Wootten
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 5:55 am
4a. Facility Name (If not Institution, give street and number): Manor Care
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-46-5461
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 23, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Burtonsville
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 4415 Sandy Spring Road
10f. Zip Code: 20866
10g. Citizan of What Country?: USA

11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Dacedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Spacify only highast grada completed): Elamantary/Secondary (0-12): 1 | College (1-4or 5+): Ø
16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired): Housekeeper
16b. Kind of Businass/Industry: Private Homes

17. Fathar's Nama (First, Middla, Last): John T. Wootten
18. Mother's Nama (First, Middla, Maidan Surnama): Ida May Coursey

19a. Informant's Name/Relationship (Type, Print): Lisa Becraft/Personal Rep.
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 4415 Sandy Spring Road, Burtonsville, MD 20866

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cemetery, cramatory or othar place): Union Cemetery
Data: 2/3/01
20c. Location - City or Town, Stata: Burtonsville, MD

21. Signatura of Funaral Sarvica Licansa: Janice Donaldson M00160
22. Nama and Addrass of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Entar the disaasa, or complications that ceused tha daath. Do not antar the moda of dying, such as cardiac or raspiratory errast, shock, or haart failure. List only ona cause on each lina.

Approximeta Intarval Batween Onset and Death

Immadiata Causa (Finai disaasa or condition rasulting in death): a. Urosepsis — 2 Weeks

Dua to (or as a consequance of):

Sequentially list conditions, if any, laading to immadiata ceuse. Entar Underlying Causa (Disease or injury that initiated avents rasulting in death) Last:
b. Dua to (or as a consequance of):
c. Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa given in Part I.

Diabetes Mellitus Type I

Organic Brain Syndrome

Breast Cancer

23b. **Did tobacco use contribute to the causa of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings availebla prior to completion of causa of death? 1☐ Yas 2☐ No

25. Wes cesa referrad to medical examinar? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☒ Nursing Home 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To tha bast of my knowiedge, death occurrad at tha tima, deta and place, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examinar:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and piace, and dua to the cause(s) and mannar stated.

29b. Signatura and title of certifier: Robert Maggin MD
29c. Licansa number: D25422
29d. Data signed (Month, Day, Year): January 31, 2001

30. Name and eddrass of person who completed ceuse of deeth (Item 23a) (Type, Print): Robert Maggin, MD 13952 Baltimore Avenue, Laurel, MD 20707

State Registrar

31. Deta filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 03075

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Raymond H. Wrobleski
2. Date of Death Month: January Day: 16, Year: 2001
3. Time of Death: 0630
4a. Facility Name *(If not institution, give street and number)*: Sharon Nursing Home
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 375-01-5383
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 92 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 9, 1908
9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 18430 Brook Grove Road
10f. Zip Code: 20850
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Photo Engraver
16b. Kind of Business/Industry: Photography

17. Father's Name *(First, Middle, Last)*: Boleslaus Wroblewski
18. Mother's Name *(First, Middle, Maiden Surname)*: Michalina Rozmaryowski

19a. Informant's Name/Relationship *(Type, Print)*: Gayle Kok / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14600 Claude Lane, Silver Spring, Maryland 20904

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory
Date: 01/17/01
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE RENAL FAILURE — DAYS

Due to (or as a consequence of):
b. DEHYDRATION — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. DYSPHAGIA — WEEKS

Due to (or as a consequence of):
d. ADVANCED DEMENTIA — YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] ATTENDING PHYSICIAN
29c. License number: D42046
29d. Date signed *(Month, Day, Year)*: JANUARY 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 20860

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03076

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Yazvac Jr.
2. Date of Death: Month January Day 16 Year 2001
3. Time of Death: 1:30pm
4a. Facility Name (If not institution, give street and number): 2674 Walston Road
4b. City, Town, or Location of Death: Mt. Airy
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 236-14-0620
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 15 1915
9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: Md
10b. County: Carroll
10c. City, Town or Location: Mt. Airy
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2674 Walston Road
10f. Zip Code: 21771
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1944
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): machinest
16b. Kind of Business/Industry: Rubberset Co.

17. Father's Name (First, Middle, Last): George Yazvac Sr.
18. Mother's Name (First, Middle, Maiden Surname): Theresa Yurecek

19a. Interment's Name/Relationship (Type, Print): Grace Langrill Yazvac (spouse)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2674 Walston Rd., Mt. Airy 21771

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): All County Cremation | Date: 1-18-01
20c. Location - City or Town, State: Sykesville, Md

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert
22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195, Sykesville, Md 21784

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC PROSTATE CA — 11 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Flavio Kruter MD
29c. License number: D35398
29d. Date signed (Month, Day, Year): 1-17-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FLAVIO KRUTER, M.D. 555 S. CENTER ST. WESTMINSTER, MD. 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #7, 19B PER F.H. G792 2-6-01 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LLOYD Allen ARRINGTON

2. Date of Death Month: February Day: 01 Year: 2001

3. Time of Death: 10:44 p.m. 03077

4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 218-42-4921

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): ~~54~~ 55 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5/10/1945

9. Birthplace (State or Foreign Country): N. C.

Usual Residence of Decedent

10a. State: Md. 10b. County: n/a 10c. City, Town or Location: Baltimore 10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1028 Rutland Ave 10f. Zip Code: 21205 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th grade College (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self employed

16b. Kind of Business/Industry: Self employed

17. Father's Name (First, Middle, Last): Edward Arrington

18. Mother's Name (First, Middle, Maiden Surname): Elenor Johnson

19a. Informant's Name/Relationship (Type, Print): Sandra Arrington (w, 7E)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 192 N. MILTON AVE. BALTO. MD 21213

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woshell Cem. Date: 2/7/2001

20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: Patricia Butts

22. Name and Address of Facility: Butts Funeral Home 1129 n. Caroline St. Balto. Md. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. END STAGE LIVER DISEASE — 1 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anastasios P. Saliaris MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): FEBRUARY 1 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANASTASIOS P. SALIARIS JOHNS HOPKINS HOSPITAL TOWER 110 BALTIMORE MARYLAND 21287

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03078

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James K. Ames Sr.

2. Date of Death: Month February Day 3 Year 2001

3. Time of Death: 0506

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 213-14-9749

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03 31 22

9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1605 North Bentalou Street

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1 [ ] Never Married 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U,S. Armed Forces? [XX] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes [XX] No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+): 4yrs

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Stocker

16b. Kind of Business/Industry: Eastern Stainless Steel

17. Father's Name (First, Middle, Last): Harry J. Ames

18. Mother's Name (First, Middle, Maiden Sumame): Anna L. Garrett

19a. Informant's Name/Ratalionship (Type, Print): Minnie B. Ames-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1605 North Bentalou Street, Baltimore Md 21215

20a. Method of Disposition: [XX] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Arbutus Memorial Park

Date: 2/7/01

20c. Location - City or Town, State: Arbutus, Md

21. Signeture of Funeral Service Licensee: Dale March

22. Name and Address of Fecility: March F/H West, 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. Renal Failure

Due to (or as a consequance of):

b. Hypertension

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [✓] No

26. Place of Death (Check only one)

Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) and manner steted.

29b. Signature and title of certifier

29c. License number: P14577

29d. Date signed (Month, Day, Year): February 3, 2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): Edgar Henriques MD c/o Maryland General Hospital

State Registrar

31. Dete filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

JAMES AMES
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

01-0573-510
HENRIETTA ASHE
ASP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03079

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Henrietta	G.	Ashe	FEBRUARY 02 2001	01045 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
12 N. ASHBURTON ST.	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-26-1388	1☐ M 2☒ F	75 Yrs.			09 01 25	V.A.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12 North Ashburton Street	21223	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced XX	1☐ Yes 2☒ No If Yes, Give Year or Dates: XX	1☐ Yes 2☒ No Specify: XX	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th grade	na	Domestic Worker	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Wilson Sheppard	Eleanora E. Walker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Willie Jackson-Nephew	12 North Ashburton Street, Baltimore Md 21223

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) XX	MD National Park	2/7/01	Laurel, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Dale March	March F/H West 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Cardiovascular Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnency 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) SCEN

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis J. Cluteau	O.C.M.E	FEBRUARY 02, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Cluteau 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 06 2001	▶ Geneva B. Brooks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CPS
01-0514-005
EMONDS ALEXANDER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED# 23a,b,27 per ME G793 031901 SS

Certificate of Death

Reg. No. 2001 03080

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Emonds A. Alexander	January 30, 2001	11:55AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTHWEST HOSPITAL CENTER	RANDALLSTOWN	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-48-7102	XX 1☐M 2☐F	53 Yrs.			July 15, 1947	No. Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Owings Mills	1☐Yes 2☐No XX

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
204 Midpines Court Apt 2B	21117	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married X 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No XX Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Maintenance Supervisor	Home Properties of New York

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Emonds Alexander	Myrtle Hammonds

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Paulette Alexander Wife	204 Midpines Ct. Apt 2B Owings Mills, MD 21117

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Druid Ridge Cemetery	2/3/01	Pikesville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Lynn B. Henss	Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC ARRHYTHMIA	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? XX 1☐Yes 2☐No

26. Place of Death (Check only one) — Hospital: 1☐Inpatient 2☒ER/Outpatient X 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) — 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. X

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis J. Chutkow	OCME	JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chutkow 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 06 2001	ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03081

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CATHERINE YOUNG WICKES ALEXANDER
2. Date of Death (Month, Day, Year): FEBRUARY 1, 2001
3. Time of Death: 7:30 PM
4a. Facility Name *(If not institution, give street and number)*: 11 DEVON HILL ROAD
4b. City, Town, or Location of Death:
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 007-20-6984
6. Sex: 1☐ M XX F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10-22-1922
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes XX No
10e. Street and Number: 11 DEVON HILL ROAD
10f. Zip Code: 21210
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX No *Specify:*
14. Reca - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 1 YEAR
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE
16b. Kind of Business/Industry: OWN HOME

17. Father's Nama *(First, Middle, Last)*: WALTER FOREMAN WICKES
18. Mothar's Name *(First, Middle, Meiden Surneme)*: CATHERINE YOUNG

19a. Informant's Name/Ralationship *(Type, Print)*: CLAY RICHARDSON (ATTORNEY)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stata, Zip Code)*: 1180 EMERALD RIDGE DR., WESTMINSTER, MD. 21158

20a. Method of Disposition: 1☐ Burial XX Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: GREEN MOUNT CREMATORY — Date: 2-2
20c. Location - City or Town, Stata: BALTIMORE, MD., 21202

21. Signature of Funeral Service Licensee: R. H. Run
22. Name and Address of Facility: HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD, BALTIMORE, MARYLAND, 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona causa on aach lina.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	PNEUMONIA	36 HRS
Due to (or as a consequence of):		
b.	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	20 YRS
Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part ff. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT (1980)

CHRONIC URINARY TRACT INFECTION

DEMENTIA (MULTI INFARCT)

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa rafarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifiar: [signature] MD
29c. License number: D12399
29d. Data signed *(Month, Dey, Year)*: FEBRUARY 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES O'DONOVAN IV, MD 6616 N. CHARLES ST #569 BALTIMORE, MD 21204

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 06 2001
32. Registrar's Signature: Geneva B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03082

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pearl Brown

2. Date of Death: Month February, Day 1, Year 2001

3. Time of Death: 8:10 pm

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 217-24-9768

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): 6-16-1917

9. Birthplace (State or Foreign Country): N. C.

Usual Residence of Decedent

10a. State: Md. | 10b. County: n/a | 10c. City, Town or Location: Baltimore | 10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 1223 E. North Ave. | 10f. Zip Code: 21202 | 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedant's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade | College (1-4or 5+): n/a

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self employed

16b. Kind of Business/Industry: Self employed

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Walter Dickey (nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1223 E. North Ave. Baltimore Md. 21202

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Cem. | Date: 2/5/2001

20c. Location - City or Town, State: Arbutus, Md.

21. Signature of Funeral Service Licensee: Patricia Bell

22. Name and Address of Facility: Bell Funeral Home 1129 N. Caroline St. Balto. Md. 21213

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one causa on each lina.

		Approximate Interval Between Onset and Death
Immedieta Cause (Final disaase or condition resulting in daath) a.	Septic Shock	3 days
Due to (or as a consequance of):		
Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaase or Injury that initieted events rasulting in death) Last b.	End Stage Renal Disease	10 years
Due to (or as a consequence of):		
c.	Peripheral Vascular Disease	10 years
Due to (or as a consequence of):		
d.	Diabetes Mellitus	30 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Daath (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C. Galang

29c. License number: AT 2438946

29d. Date signed (Month, Day, Year): February 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARLA GALANG Union Memorial Hospital E. University Pkwy Baltimore, MD 21218

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To Be Completed by Funeral Director

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03083

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dale Belcher

2. Date of Death (Month, Day, Year): Feb. 4, 2001

3. Time of Death: 4:45AM

4a. Facility Name (If not institution, give street and number): Joseph Richey Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-36-7665

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 14, 1940

9. Birthplace (State or Foreign Country): KY

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 116 S. Mount Street

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter

16b. Kind of Business/Industry: Home Improvement

17. Father's Name (First, Middle, Last): Jack Donald Belcher

18. Mother's Name (First, Middle, Meiden Surneme): Mary Marie Rye

19a. Informant's Neme/Relationship (Type, Print): Carrie Pearson, sister

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 8204 Hook Rd. Millersville, MD. 21108

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other placa): Metro Crematory

Date: 2-5-01

20c. Location - City or Town, Steta: Catonsville, MD

21. Signeture of Funeral Service Licensee: Alan F. Ambrose

22. Name and Address of Facility: Ambrose Funeral Home of Lansdowne, 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Ca of lung c 7 mos.

Due to (or as a consequence of):

b. bone mets, 2° analysis of lung

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. extremities

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Schizophrenia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) end menner as stated. 2☐ **Medicel Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael R. Hayes, MD

29c. License number: D 02280

29d. Date signed (Month, Day, Year): 2/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Michael Hayes 2402 Hemlock Ave. Baltimore, MD 21214

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrer's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28d-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dale Belcher 2/4/01 5:30 Am

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03084

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ralph Bailey, Jr.

2. Date of Death: Month 1 Dey 26 Year 01

3. Time of Death: 4:15 AM

4a. Facility Name (If not institution, give street and number): Prince Georges Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 410-22-6084

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 25, 26

9. Birthplace (State or Foreign Country): Knoxville, Tn

Usual Residence of Decedent

10a. State: D C

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 3700 North Capitol Street, NW

10f. Zip Code: 20317

10g. Citizen of Whet Country?: U. S. A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 11/44

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Professional Soldier

16b. Kind of Business/Industry: U S Army

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Neme (First, Middle, Meiden Surneme): Unknown

19a. Informant's Name/Relationship (Type, Print): Matthrew A. Hinton/Mortuary Officer

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3700 N. Capitol St, NW Wash., DC 20317

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Arlington National Cem | Date: 2/8/01

20c. Location - City or Town, Stete: Arlington, Va.

21. Signature of Funeral Service Licensee: CC0348

22. Name end Address of Facility: Latney's Funeral Home, Inc. 3831 Georgia Avenue, NW Wash., DC 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): a. Arteriolosclerotic Cardiovascular Disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End Stage Renal Disease; Respiratory Failure

23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an eutopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D01852

29d. Date signed (Month, Day, Year): 1/ 29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul A. De Vore MD 4203 Queensbury Road, Hyattsville, Maryland 20781

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03085

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ESSIE BLACK
2. Date of Death: Month FEB Day 5 Year 2001
3. Time of Death: 2:47 A.M.
4a. Facility Name (If not institution, give street and number): Mercy Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-22-5515
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 14, 1914
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2616 Ashland Avenue
10f. Zip Code: 21205
10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 / College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: Housekeeping

17. Father's Name (First, Middle, Last): John Martin
18. Mother's Name (First, Middle, Maiden Surname): Annie Belle Gladney

19a. Informant's Name/Relationship (Type, Print): Barbara J. Sawyer Grand-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2616 Ashland Ave. Balto., MD 21205

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. MATTHEWS BYT #2
Date: 2-10-01
20c. Location - City or Town, State: BLAIR, SC

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SMITH & WILLIAMS FUNERAL HOME, P.A. 2818 East Baltimore, MD 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ACUTE SEPTICEMIA	2 DAYS
Due to (or as a consequence of): b.	INFECTED DECUBITUS ULCER	2 WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	SEVERE DEBILITATION	6 WEEKS
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph D. Notarangelo M.D.
29c. License number: D07316
29d. Date signed (Month, Day, Year): FEB. 5 - 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH D. NOTARANGELO M.D. 301 ST. PAUL PLACE BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03086

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alma Marie Burmeister

2. Date of Death — Month: February Day: 1 Year: 2001

3. Time of Death: 7:20 A.M.

4a. Facility Name *(If not institution, give street and number)*: Mariner Health of North Arundel

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215 10 0287

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 94 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Dec. 10, 1906

9. Birthplace *(State or Foreign Country)*: Louisiana

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1104 Riverside Drive

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: (unknown) Myers

18. Mother's Name *(First, Middle, Maiden Surname)*: Josephine Brown

19a. Informant's Name/Relationship *(Type, Print)*: Kathleen Busch / Niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7904 Oak Point Road Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Memorial Park

Date: 2/3/01

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Donna Broniewski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimers. — 10 yr.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Bronchitis / Pneumonia — 10 days.

Due to (or as a consequence of):

c. Respiratory failure. — 3 days

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shreedhar Reddy MD

29c. License number: D30568

29d. Date signed *(Month, Day, Year)*: 2.1.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SHOBHA D. Reddy 7845 OAKWOOD RD. STE 204 Glen BURNIE MD. 21061

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001

32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03087

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERT BERG
2. Date of Death: Month FEBRUARY Day 2 Year 2001
3. Time of Death: 02:28
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 207-10-8495
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT 26, 1913
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Pennsylvania
10b. County: Cumberland
10c. City, Town or Location: Mechanicsburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: P.O. Box 457
10f. Zip Code: 17055
10g. Citizen of What Country?: USA
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Self-Employed
17. Father's Name (First, Middle, Last): Herman Berg, Jr.
18. Mother's Name (First, Middle, Meiden Surname): Pearl Weiss
19a. Informent's Name/Reletionship (Type, Print): Thomas H. Berg/Nephew
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 130 Parker Street Carlisle, PA 17013
20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Cremation Society of PA Crematory
Dete: 2-6-01
20c. Location - City or Town, State: Harrisburg, PA
21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name end Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in death)
a. SEPSIS — 16 HOURS

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, term, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the cause(s) snd menner steted.

29b. Signature and title of certifier: David C. Loft, M.D.
29c. License number: RES000
29d. Date signed (Month, Dey, Year): FEBRUARY 2, 2001

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): DAVID C. LOFT, M.D. SINAI HOSPITAL, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MARYLAND 21215

State Registrar

31. Dete filed (Month, Day, Year): FEB 0 6 2001
32. Registrar's Signature: Serena B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

0314

2/3/01

BOYCE, CHARLOTTE WADE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03088

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charlotte Wade Boyce

2. Data of Death — Month: February Day: 3 Year: 2001

3. Time of Death: 3:14 AM

4a. Facility Name (If not institution, give street and number): Harford Memorial

4b. City, Town, or Location of Death: Havre De Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 429-38-0853

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): DEC 16, 1924

9. Birthplace (State or Foreign Country): Mississippi

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Havre De Grace

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 256 Wilson Street

10f. Zip Code: 21078

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): Collega (1-4or 5+): 4

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Homemaker

16b. Kind of Businass/Industry: Domestic

17. Fathar's Nama (First, Middle, Last): Charles Wade

18. Mothar's Nama (First, Middle, Maiden Sumame): Mary Powell

19a. Informant's Name/Ralationship (Type, Print): Rebecca Boyce Lewis/Daughter

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 14832 Cranoke Street Centreville, VA 20120

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, crematory or othar placa): Metro Crematory Inc.

Data: 2-5-01

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Nama and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona cause on each line.

Approximate Intarval Batween Onsat and Death

Immedieta Causa (Final disaasa or condition resulting in death): a. Chronic obstructive pulmy disease

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. arthritis

Due to (or as a consequance of):

c. Alzheimers

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco usa contribute to the cause of death? 1☐ Yas 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to compiation of cause of death? 1☐ Yas 2☐ No

25. Was casa refarrad to medical examiner? 1☐ Yes 2☑ No

26. Placa of Death (Check only ona): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledga, daath occurred at tha time, data and placa, and due to tha cause(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to tha cause(s) and manner steted.

29b. Signature and title of cartifier: HiSupSign

29c. License number: D46912

29d. Date signad (Month, Day, Year): 2/3/01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): HiSupSign 319 S. Union Ave Hbr de Grace MD 21078

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dr Sin

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03089

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald E. Brady, Sr.
2. Date of Death (Month, Day, Year): February 5, 2001
3. Time of Death: 4:35am
4a. Facility Name (If not institution, give street and number): VAMHCS Fort Howard Division
4b. City, Town, or Location of Death: Fort Howard
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218264969
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 20, 1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 6936 German Hill Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: Korean
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Welder
16b. Kind of Business/Industry: Steel Industry
17. Father's Name (First, Middle, Last): Norman Clarence Brady
18. Mother's Name (First, Middle, Maiden Surname): Augusta Caroline Hagie
19a. Informant's Name/Relationship (Type, Print): Mrs. Charlotte Brady (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6936 German Hill Road Dundalk, Maryland 21222
20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. Date: 2/06/2001
20c. Location - City or Town, State: Towson, Maryland
21. Signature of Funeral Service Licensee: Diego E. Ruck
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. COPD — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D52739
29d. Date signed (Month, Day, Year): February 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suresh Shandelya, MD 9600 North Point Road Fort Howard MD 21052

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Name: Donald E. Brady
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03090

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GRACE ELIZABETH BROSH
2. Date of Death: Month FEBRUARY Day 03 Year 2001
3. Time of Death: 0638
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-03-3813
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 22, 1916
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: BAltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1721 Rita Rd.
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Frederick Stolte
18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Reisig

19a. Informant's Name/Relationship (Type, Print): Joseph F. Brosh son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1311 H. Sheraton Place, Belair, Md. 21015

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cem
Date: Feb. 6, 2001
20c. Location - City or Town, State: Dundalk, MD.

21. Signature of Funeral Service Licensee: ▶ Anthony C. Connelly
22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers POint Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. END-STAGE RESTRICTIVE LUNG DISEASE — 1 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEVERE ANEMIA
MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ John David Martin MD
29c. License number: 21009
29d. Date signed (Month, Day, Year): FEBRUARY 03 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LORRIN DAVID MARTIN JOHNS HOPKINS BAYVIEW MEDICAL CENTER

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #26 PER PHY G792 2-6-01 WR.

Certificate of Death

Reg. No. 2001 03091

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM JOSEPH BOWERS
2. Date of Death (Month, Day, Year): 01 28 2001
3. Time of Death: 9:10 AM
4a. Facility Name (If not institution, give street and number): St. Joseph's Hospital
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-10-3587
6. Sex: 1 ☐ M 2 ☐ F — X
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 18 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 800 Southerly Rd.
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): n/a
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: State of MD Court System

17. Father's Name (First, Middle, Last): William Bowers
18. Mother's Neme (First, Middle, Maiden Surname): Pearl L. Duckett

19a. Informent's Name/Relationship (Type, Print): Shirley Frome/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13811 Ansari Ln., Baldwin, MD 21013

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Name of cemetary, crematory or other place): New Cathedral Cem.
Date: 1/31/01
20c. Location - City or Town, State: Balto., MD

21. Signature of Funeral Service Licensee: ▶ Michael J. Flagle
22. Neme and Address of Facility: Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrast, shock, or haart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediete Cause (Final disease or condition resulting in death)
e. any cardiac arrhythmia — 1d
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaese or Injury thet initieted evants resulting in death) Last
b. severe chronic obstructive lung disease — 10yr
Due to (or es a consequence of):
c. atherosclerotic disease — 10yr
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify)

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be datarmined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To tha best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and mannar as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and piece, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] physician
29c. License number: D29769
29d. Date signed (Month, Day, Year): 1/29/01
30. Neme and address of person who complated cause of death (Item 23a) (Type, Print): [illegible] MD 516 W. Rd Towson Balto md 21228

State Registrar

31. Dete filed (Month, Day, Year): FEB 0 6 2001
32. Registrar's Signeture: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #8 PER F.H. G792 2-7-01 WR.

Certificate of Death

Reg. No. 2001 03093

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONALD R BRENT
2. Date of Death Month Day Year: January 26, 2001
3. Time of Death: 1:25 Am
4a. Facility Name (If not institution, give street and number): The Good Samaritan Hospital of Maryland
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214 44 7464
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 55 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): ~~2-1~~ 2/21 1945
9. Birthplace (State or Foreign Country): CALIFORNIA

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 813 REVERDY RD.
10f. Zip Code: 21212
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -12- College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGEMENT
16b. Kind of Business/Industry: BETHLEHEM STEEL

17. Father's Name (First, Middle, Last): JAMES R. BRENT
18. Mother's Name (First, Middle, Maiden Surname): BERNESTINE D. BELL

19a. Informant's Name/Relationship (Type, Print): LYNDA D. BRENT(SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 585 MacARTHUR BLVD. #25 OAKLAND, CALIFORNIA 94610

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST VETERANS
Date: 2-6-2001
20c. Location - City or Town, State: OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee: Jaratha D. Hubner
22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Duodenal Carcinoma	9 months
Due to (or as a consequence of):	b. Liver failure	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Qinglin Gao MD
29c. License number: P14417
29d. Date signed (Month, Day, Year): January 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): QINGLIN GAO 5601 Loch Raven Boulevard, Baltimore, MD 21239-2995

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Bernice G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03092

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH BURKOWSKE

2. Date of Death (Month, Day, Year): FEBRUARY 1, 2001

3. Time of Death: 2:10 PM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-03-4962

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 4 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Woodlawn

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6413 Lehnert Street

10f. Zip Code: 21207

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Emil Fritz

18. Mother's Name (First, Middle, Maiden Surname): Elsie F. Thiel

19a. Informant's Name/Relationship (Type, Print): Donald Burkowske - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 755 Arncliffe Road; Baltimore, MD 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial Park

Date: 2/5/01

20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: Joseph Kellner #00333

22. Name and Address of Facility: Loring Byers Funeral Directors Inc. 8728 Liberty Road; Randallstown, MD 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — 1 HOUR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE — YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION; RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably ~~4☐~~ Unknown

24a. Was an autopsy performed? 1☐ Yes ~~2☐~~ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes ~~2☐~~ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient ~~3☐~~ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: ~~1☐~~ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): ~~1☐~~ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D47587

29d. Date signed (Month, Day, Year): FEBRUARY 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT FINE, MD 5401 OLD COURT ROAD, RANDALLSTOWN, MD 21133

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #18 PER F.H. G792 2-6-01 WR.

Certificate of Death

Reg. No. 2001 03094

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
NAUM	BERENSHTEYN	FEBRUARY 3, 2001	11:00PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5900 PARK HEIGHTS AVENUE #515	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-37-3711	1 [X] M 2 [ ] F	70 Yrs.			MAY 5,1930	UKRAINE

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1 [X] Yes 2 [ ] No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5900 PARK HEIGHTS AVENUE #515	21215	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	CIVIL ENGINEER	ENGINEERING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ISRAEL BERENSHTEYN	OLGA ARONOVICH ~~ARONOVITCH~~

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
FAINA VAYNERMAN / WIFE	5900 PARK HEIGHTS AVENUE #515 - BALTIMORE, MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	CHIZUK AMUNO (ARLINGTON)	2/5/01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert Thomas	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Coronary artery D-S.	
Due to (or as a consequence of):	b. Hypertension	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Diabetes Mellitus	
Due to (or as a consequence of):	d. Chronic Renal Failure.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A Pokov M.D.	D0054746	02/04/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A. POKOV, M.D 6821 Reisterstown Rd #206, Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 06 2001	▶ Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #17 PER F.H. G792 2-6-01 WR. *Certificate of Death* Reg. No. 2001 03095

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
JUDITH		BENNETT	FEBRUARY 2, 2001	11:30PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOSPICE OF BALTIMORE GILCHRIST CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
456-66-8290	1☐ M 2☒ F	59 Yrs.			FEB. 20, 1941	HUNGARY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	RANDALLSTOWN	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9339 EDWAY CIRCLE	21133	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	SPEECH & LANGUAGE PATHOLOGIST	EDUCATION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
DAVID DOSKAL ~~DASKAL~~	JEANETTE REICH RELCH

19a. Interment's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MORDECAI BENNETT / HUSBAND	9339 EDWAY CIRCLE - RANDALLSTOWN, MD 21133

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	OHEB SHALOM MEMORIAL PARK	2/4/01	REISTERSTOWN, MD

21. Signature of Funeral Service Licensee: ▶ Scott M. Cuttler

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Adenocarcinoma of uncertain	
Due to (or as a consequence of):	b. primary site, possibly colorectal	3 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Date signed (Month, Day, Year)
▶ W. Anthony Riley, MD	D25205	February 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 0 6 2001	Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Bennett, Judith 2/2/01 11:30 pm

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

01-0511-510
crn
Oscar B Craine

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03096

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Oscar B. Craine Jr.
2. Data of Death: Month January Day 30 Year 2001
3. Time of Death: 11:55 P.M.
4a. Facility Name (If not institution, give street and number): 4901 Challedon Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-42-3098
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10 30 42
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4901 Challedon Road Apt 8
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, Whita, etc. Specify: Black

15. Decedent's Education (Specify only highest grade complatad)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+): na
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Social Security Adm

17. Father's Name (First, Middle, Last): Oscar Craine Sr
18. Mother's Name (First, Middle, Maiden Surname): Bernice Terry

19a. Informant's Name/Relationship (Type, Print): Cheryl Craine-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1914 Halboro Ct. Severn Maryland 21144

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet.
Data: 2/7/01
20c. Location - City or Town, Stata: Owings Mills, Md

21. Signature of Funeral Service Licensee: Dale March
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused tha death. Do not enter the moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive and Arteriosclerotic
Due to(or as a consequence of):
b. Cardiovascular Disease

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? Limited. 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to complation of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [X] Other (Specify) at scene

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Pestaner, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 02, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #30 PER D.V.R G792 2-6-01 WR. *Certificate of Death* Reg. No. 2001 03097

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN DENNIS COATES
2. Date of Death (Month, Day, Year): FEB. 4, 2001
3. Time of Death: 6:15 a.m.
4a. Facility Name (If not institution, give street and number): 3319 ALTO RD.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215 16 1168
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 29, 1914
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 3319 ALTO RD.
10f. Zip Code: 21216
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): UNKNOWN
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ENTREPRENEUR
16b. Kind of Business/Industry: CULINARY ARTS

17. Father's Name (First, Middle, Last): JAMES H. COATES
18. Mother's Name (First, Middle, Maiden Surname): JULIA ANN CHASE

19a. Informant's Name/Relationship (Type, Print): GAITHER L. COATES-WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3319 ALTO RD. BALTIMORE, MARYLAND 21216

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEM. PARK
Date: 2/9/01
20c. Location - City or Town, State: ARBUTUS MARYLAND

21. Signature of Funeral Service Licensee: Lewis T. Gwynn
22. Name and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 4517 PARKHEIGHTS AVE BALTO. MD. 21215-6393

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure
Due to (or as a consequence of): b. Pneumonia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atherosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robert Kroopnick
29c. License number: M1973
29d. Date signed (Month, Day, Year): 2/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT B. KROOPNICK 4000 OLD COURT RD. SUITE 300

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Deputy G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03098

Cole, Edith Feb. 2, 2001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Edith Cole	2 / 2 / 2001	5:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
219 Willow Avenue	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-52-8661	1☐ M 2☑ F	94 Yrs.			Nov 7, 1906	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Towson	1☐ Yes 2☑ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
219 Willow Avenue	21286	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced	1☐ Yes 2☑ No If Yes, Give Year or Dates:	1☐ Yes 2☑ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Josiah Lentz	Susie May Stricker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bonnie Chenowith /Niece	219 Willow Avenue, Towson, MD 21286

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Chesapeake Crematory	Feb 6 2001	Beltsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] M00986	Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9958.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aortic Stenosis	10 yrs
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Congestive Heart Failure	1 yr
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery Disease

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown	1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Barbara Kirchner	D37134	2-5-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara Kirchner, M.D. 5601 Loch Raven Blvd. #412 Baltimore, Md. 21239

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 0 6 2001	[signature] / S. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03099

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLARA FERN COMPTON
2. Date of Death (Month, Day, Year): JAN. 31, 2001
3. Time of Death: 11:55PM
4a. Facility Name (If not institution, give street and number): GENESIS ELDERCARE
4b. City, Town, or Location of Death: DUNDALK
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-14-9121
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 4, 1921
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 727 UMBRA STREET
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 6TH; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CASHIER
16b. Kind of Business/Industry: DEPT. STORE

17. Father's Name (First, Middle, Last): FRANK HUBER
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN CHAMBERLIN

19a. Informant's Name/Relationship (Type, Print): LUEN N. COMPTON, SR. HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 727 UMBRA STREET BALTIMORE, MD. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SACRED HEART OF JESUS
Date: 2/3/01
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Richard Wenderoth 10521
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	3 DAYS.
Due to (or as a consequence of):	b. CORONARY ARTERY DISEASE	10 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of):	c. ESSENTIAL HYPERTENSION	20 YEARS
	d. DIABETES MELLITUS	28 YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harjit Singh ATTENDING M.D. PHYSICIAN
29c. License number: D14160
29d. Date signed (Month, Day, Year): FEBRUARY 01, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HARJIT SINGH M.D. 5410-A RITCHIE HIGHWAY, BALTIMORE, MARYLAND 21225.

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03100

Physician /Medical Examiner

1. Decedent's Nsme *(First, Middle, Last)*: Walter E. Claypoole

2. Dete of Desth — Month: February Day: 02 Year: 2001

3. Time of Death: 6:50AM

4a. Facility Name *(If not institution, give street end number)*: Holly Hill Manor, Inc.

4b. City, Town, or Location of Desth: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-18-0157

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. lest birthdey)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: April 9 1925

9. Birthplece *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Md.

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 205 E. Joppa Rd. #2305

10f. Zip Code: 21286

10g. Citizen of Whet Country?: USA

11. Meritsl Stetus: 1 ☐ Never Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): +4

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Insurance Agent

16b. Kind of Business/Industry: Insurance

17. Father's Neme *(First, Middle, Last)*: Christian L. Claypoole

18. Mother's Neme *(First, Middle, Maiden Surname)*: Martha A. Lewis

19a. Informent's Neme/Reletionship *(Type, Print)*: Mrs. Delores S. Claypoole/ Wife

19b. Melling Address *(Street and Number or Rural Route Number, City or Town, Stste, Zip Code)*: 205 E. Joppa Rd. #2305 Towson, Md. 21286

20a. Method of Disposition: 1 ☐ Burisl 2 ☒ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Hilltop Service Co. — Dete: 2- 05 -01

20c. Location - City or Town, Stete: Towson, Md.

21. Signeture of Funerel Service Licensee ▶ [signature]

22. Neme end Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Final diseese or condition resulting in deeth): a. Cerebrovascular Accident — 1 week

Due to (or es a consequence of):

Sequentially list conditions, if any, feeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Last: b. ____ Due to (or es e consequence of): c. ____ Due to (or es e consequence of): d. ____

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes sn sutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Menner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) and menner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier ▶ [signature] MD

29c. License number: D-17041

29d. Dete signed *(Month, Dey, Yeer)*: 02 FEBRUARY 2001

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): MARC I. LEAVEY MD. 1205 YORK ROAD STE 38 LUTHERVILLE MD 21093

State Registrar

31. Dete filed *(Month, Day, Yeer)*: FEB 0 6 2001

32. Registrer's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03101

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosaline Agnes Chell

2. Date of Death: Month February Day 2 Year 2001

3. Time of Death: 5:20 AM

4a. Facility Name (If not institution, give street and number): Gilchrist Hospice Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-05-5691

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 13, 1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8809 Groffs Mill Road

10f. Zip Code: 21117

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Bernard Martin

18. Mother's Name (First, Middle, Maiden Surname): Julia Kelly

19a. Informant's Name/Relationship (Type, Print): Rosalyn Thibodeau - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10623 Partridge Lane; Cockeysville, MD 21030

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Balto/Wash Crematory

Date: 2/3/01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Joseph Kellner Joseph J Kellner #100333

22. Name and Address of Facility: Loring Byers Funeral Directors Inc. 8728 Liberty Road; Randallstown, MD 21133

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

02-02-01 @ 5:30 PM

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Primary Biliary cirrhosis — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): February 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Chell, Rosaline

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03102

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NOVELLA ANN CARTER

2. Date of Death (Month, Day, Year): February 4, 2001

3. Time of Death: 5:11 am

4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-22-5465

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 7-16-1907

9. Birthplace *(State or Foreign Country)*: NORTH CAROLINA

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1005 BRANTLEY AVE.

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): -6- / College (1-4or 5+): -0-

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE

16b. Kind of Business/Industry: DOMESTIC

17. Father's Name *(First, Middle, Last)*: ROOSEVELT BRYANT

18. Mother's Name *(First, Middle, Maiden Surname)*: MAMIE BRYANT

19a. Informent's Name/Relationship *(Type, Print)*: JOHN CARTER(HUSBAND)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1005 BRANTLEY AVE. BALTIMORE, MARYLAND 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: GARRISON FOREST VETERANS

Date: 2-8-2001

20c. Location - City or Town, State: OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee: Jonathan D. Hibner

22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or es e consequenca ot):

b. Hypotension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or es e consequence of):

c. Unresponsive Bradycardia

Due to (or es e consequenca of):

d.

Part ff. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings availiable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Willie Williams M.D.

29c. License number: P14585

29d. Date signed *(Month, Day, Year)*: February 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Willie Williams M.D. 40 Maryland General Hospital

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001

32. Registrar's Signature: Emma G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

NOVELLA CARTER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03103

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DOUGLAS D. DORSEY

2. Date of Death (Month, Day, Year): FEBRUARY 4, 2001

3. Time of Death: 3:00PM

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: AA COUNTY

Funeral Director

5. Social Security Number: 214.56.1698

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV 22 1951

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 506 OAKWOOD STATION RD.

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: VIETNAM

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: COOK

16b. Kind of Business/Industry: HARDEES

17. Father's Name *(First, Middle, Last)*: WALTER D. DORSEY

18. Mother's Name *(First, Middle, Maiden Surname)*: VERA H. HILGARTNER

19a. Informant's Name/Relationship *(Type, Print)*: CHERYL DORSEY WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 506 OAKWOOD STATION RD GLEN BURNIE, MD 21061

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BAYVIEW CREMATORY INC Date: 8FEB01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature & Funeral Service License: ▶ R. GREGORY FINK MO1148

Name and Address of Facility: FINK FUNERAL HOME, P.A. 426 CRAIN HWY S GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in death): a. CARCINOMA OF THE LUNG

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest:

b.

Due to (or es e consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC MALNUTRITION, DEHYDRATION

DECUBITUS ULCER

23b. Did tobacco use contributs to the causs of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Plece of Deeth *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: ▶ MD

29c. License number: D43977

29d. Dete signed *(Month, Day, Year)*: February 4 2001

30. Neme and addess of person who completed cause of death (Item 23a) (Type, Print): Cryden Oncology. 301 Hospital Drive, Glen Burnie. MD 21061

State Registrar

31. Date filed *(Month, Dey, Year)*: FEB 06 2001

32. Registrer's Signeture

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DOUGLAS DORSEY

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03104

DODSON, MAXINE O.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maxine Ophelia Dodson
2. Date of Death (Month, Day, Year): FEBRUARY 02 2001
3. Time of Death: 6 AM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 261 28 5293
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 9, 1921
9. Birthplace (State or Foreign Country): Florida

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3504 Horton Avenue
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Max Hilliard
18. Mother's Name (First, Middle, Maiden Surname): Jessie Pearce

19a. Informant's Name/Relationship (Type, Print): Virginia Joyce Snoots
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14419 Barkwood Rockville, Maryland 20853

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park
Date: 2/5/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Shannon Liggett
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE RESPIRATORY FAILURE — 1 DAY

Due to (or as a consequence of):
b. PNEUMONIA — 3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D 46962
29d. Date signed (Month, Day, Year): FEBRUARY 02, 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. SHIRAZI, M.D. NORTH ARUNDEL HOSPITAL. MD 21061.

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03105

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David, L, Delcambre

2. Data of Death — Month: February Day: 02 Year: 2001

3. Time of Death: 7:59am.

4a. Facility Name (If not institution, give street and number): Veterans Affairs Hospital Baltimore

4b. City, Town, or Location of Death: Baltimore Maryland

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 434-02-7396

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 45 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): March 21, 1955

9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 464 Hornel Street

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1972-1974

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Rigger

16b. Kind of Business/Industry: Oil Industry

17. Father's Name (First, Middle, Last): Manson Bruno Delcambre

18. Mother's Name (First, Middle, Maiden Surname): Joyce MacDougall

19a. Informant's Name/Relationship (Type, Print): Michelle Leigh Delcambre/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 150 Canfield Drive Mt. Dlemens, MI 48043

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Metro Crematory, Inc.

Data: 2/5/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Distress.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hepatorenal Syndrome,

Due to (or as a consequence of):

c. Cirhosis

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Vikram MD 1326

29c. License number: AU417643SH13126

29d. Data signed (Month, Day, Year): February 2 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vikram Hatti, 10 North Green Street, Baltimore, Mylnd 21201

State Registrar

31. Data filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Jerome D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMND ITM#6 PER F.H. G794 4-5-2001 JAB
AMENDED ITEM #20b per fh G792 020601 SS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03106

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SALLIE DIGGS

2. Date of Death (Month, Day, Year): FEBRUARY 1, 2001

3. Time of Death: 11:45 am

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-36-0386

6. Sex: ~~1 M~~ 2 X F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 18, 1941

9. Birthplace (State or Foreign Country): BALTO. MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: N / A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 1252 N. BROADWAY

10f. Zip Coda: 21213

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc.: AFRO AMERICAN Specify:

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FILE CLERK

16b. Kind of Businass/Industry: SOC. SECURITY ADM.

17. Father's Name (First, Middle, Last): LINDSAY HOOKER

18. Mother's Name (First, Middle, Meiden Surneme): ANNIE TYLER

19a. Informant's Name/Ralationship (Type, Print): PAULETTA M. DIGGS DAUGHTER JORDAN

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code): 3006 MC ELDERRY st. 21205 BALTO. MD.

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): GARDENS OF FAITH MEM. GARD.

Date: 2/9/01 ~~FEB. 9, 2001~~

20c. Location - City or Town, State: BALTO. CO.

21. Signature of Funeral Service Licensee: Bernadette D. Scruggs

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD. 21213

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line.

Approximete Intarval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in daath): a. Coronary Artery Disease

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA
Othar: 4 ☐ Nursing Home 5 ☐ Rasidence 6 ☐ Othar (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicida 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, tarm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and dua to tha causa(s) and manner as stated. 2 ☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the tima, date and place, and due to the cause(s) and manner statad.

29b. Signature and title of certifier: Arnel Mendoza Tagle MD

29c. License number: D53517

29d. Date signed (Month, Dey, Year): February 02, 2001

30. Name and sddrass of person who completed cause of death (Item 23a) (Type, Print): ARNEL MENDOZA TAGLE MD
315 North Calvert Street Baltimore, Maryland 21202

State Registrar

31. Dete filed (Month, Dey, Year): FEB 06 2001

32. Registrar's Signature: Genevieve B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 03107

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EUGENE DREIGER

2. Date of Death Month / Day / Year: JAN 29 01

3. Time of Death: 6PM

4a. Facility Name *(If not institution, give street and number)*: MARINER GLEN BURNIE

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: A-A.

Funeral Director

5. Social Security Number: 220-24-8720

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 03-24-1927

9. Birthplace *(State or Foreign Country)*: MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 743 S. Luzerne Avenue

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Caucasian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Incinerator

16b. Kind of Business/Industry: Baltimore City

17. Father's Name *(First, Middle, Last)*: Joseph Drieger Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Martha Wankowski

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Daniel Drieger

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1209 Oakcroft Drive, Lutherville, MD 21093

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Stanislaus

Date: 2-1-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Charles Kaczorowski

22. Name and Address of Facility: Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue, Baltimore, MD 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE CEREBROVASCULAR ACCIDENT 5 hours

Due to (or as a consequence of):

b. OLD CEREBROVASCULAR ACCIDENT

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequence of):

c. GENERALIZED ATHEROSCLEROSIS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

AORTIC VALVE PROSTHESIS, QUADRIPLEGIA

CHRONIC ATRIAL FIBRILLATION

CARCINOMAS SKIN, COLON, PROSTATE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was cesa referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard E Fisher MD

29c. License number: D025199

29d. Date signed *(Month, Day, Year)*: Feb 2 01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Richard E Fisher 4710 Pennington Ave 21226

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001

32. Registrar's Signature: Bernice G Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03108

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leona Drexel

2. Date of Death: Month: January Day: 31 Year: 2001

3. Time of Death: 1255PM

4a. Facility Name (If not institution, give street and number): Mercy Medical Center

4b. City, Town, or Location of Death: B. It. md.

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 216-03-0744

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03-29-1915

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 232 S. Exeter Street

10f. Zip Code: 21231

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Antonio Frezza

18. Mother's Name (First, Middle, Maiden Surname): Rosina Papagno

19a. Informant's Name/Relationship (Type, Print): Mrs. Karen Bruno

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4315 Mispillian Road, Baltimore, MD 21236

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith

Date: 02-05-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Charles Kaczorowski

22. Name and Address of Facility: Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue, Baltimore, MD 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Clostrum Difficile Colitis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Antibiotic Therapy

Due to (or as a consequence of):

c. Pneumonia

Due to (or as a consequence of):

d. Disseminated Pulmonary Carcinoma

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Louis E. Granzer

29c. License number: D01442

29d. Date signed (Month, Day, Year): Jan. 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Louis E. Granzer MD 301 St. Paul Place # 815 B. It. md 21202

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03109

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy E. Ellis
2. Date of Death (Month, Day, Year): February 3 2001
3. Time of Death: 12:35 P.M.
4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 162 12 5794
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 22, 1919
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: New Windsor
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1444 Hallowell Lane
10f. Zip Code: 21776
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Datea:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Personnel Manager
16b. Kind of Business/Industry: I S O / Insurance

17. Father's Neme *(First, Middle, Last)*: (not available)
18. Mother's Name *(First, Middle, Maiden Sumeme)*: (not available)

19a. Informent's Name/Relationship *(Type, Print)*: Regina Ellis
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1444 Hallowell Lane New Windsor, Maryland 21776

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other place)*: Bayview Crematory, Inc.
Date: 2/5/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Jerome Zramiewski
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not enter tha moda of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one cause on aach lina.

		Approximata Interval Between Onset and Death
Immediata Cause (Finel disease or condition resulting in death) a.	Respiratory Arrest / Failure	5minutes
Due to (or as a consequence of): b.	Severe Chronic Obstructive Lung Disease	years
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Last — Due to (or as a consequence of): c.	Bilateral Pleural Effusions	3 weeks
Due to (or as e consequance of): d.	Congestive Heart failure	1-2 months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Severe Peripheral Vascular Disease
Chronic Atrial Fibrillation
Ischemic Right leg

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete and piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ MD
29c. Licanse number: 032654
29d. Date signed *(Month, Day, Year)*: February 3, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): John P. Serlemitsos 301 Hospital Drive, Glen Burnie, MD 21061

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 0 6 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23a perPHYG792 2/6/2001 EW

Certificate of Death

Reg. No. 2001 03110

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHEA ARBUTUS EVANS

2. Date of Death (Month, Dey, Yeer): JANUARY 10 2001

3. Time of Death: 4:47 AM

4a Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Deeth: BALTIMORE

4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 215 18 3256

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dele of Birth (Month, Day, Year): August 22,1917

9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 900 Pontiac Avenue

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Neff

18. Mother's Name (First, Middle, Maiden Surname): Mary Blanche Giles

19a. Informant's Neme/Relationship (Type, Print): Agnes Pavlick / Niece

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6206 Orchard Road Linthicum, Maryland 21090

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): Holy Cross Cemetery

Dete: 1/11/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Donna M Bremiowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth)

a. CORONARY ARTERY DISEASE ~~RESPIRATORY FAILURE~~ — ONE HOUR

Due to (or as a consequenca of):

b. CARDIAC ARREST — ONE HOUR

Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

c.

Due fo (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

PERIPHERAL VASCULAR DISEASE

CORONARY ARTERY DISEASE

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner as stated. 2☐ **Medicel Examiner:** On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sumeet Sawhney . MD .

29c. License number: P-14121

29d. Date signed (Month, Day, Year): JANUARY 10 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): SUMEET . SAWHNEY HARBOR HOSPITAL CENTER

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03111

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William W. Eversmann, Sr.

2. Date of Death Month: 02 Day: 03 Year: 2001

3. Time of Death: 08:30 am

4a. Facility Name *(If not institution, give street and number)*: Hospice of Baltimore, Gilchrist

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 192-09-1463

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 03/15/1914

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 205 East Joppa Road #2707

10f. Zip Code: 21204

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: District Manager

16b. Kind of Business/Industry: Oil Company

17. Father's Name *(First, Middle, Last)*: John Frederick Wilbert Eversmann

18. Mother's Name *(First, Middle, Maiden Surname)*: Alma Sophia Broelker

19a. Informent's Name/Reletionship *(Type, Print)*: William W. Eversmann, Jr. / son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14530 Headwater Bay Lane; Fort Myers, FL 33908

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Hilltop Service Corp. Date: 2/5/01

20c. Location - City or Town, State: Towson, MD

21. Signature of Funeral Service Licensee: Peter U Clay

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, MD 21204

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode ol dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immedlete Cause (Finel disease or condition resulting in death)

e. Respiratory Failure

Due to (or as a consequence of):

b. Idiopathic Pulmonary Fibrosis — 3 years

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

c.

Due to (or es a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary Disease

History of colon cancer and prostate cancer

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* HOSPICE INPATIENT

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete ol Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Raymond W. Wilson M.D.

29c. License number: D41476

29d. Date signed *(Month, Day, Year)*: 02/03/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Raymond W. Wilson M.D. 6565 N. Charles Street, #416, Baltimore, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001

32. Registrar's Signature: Bernard B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

February 3, 01 @ 9:30 AM

William Eversmann

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03112

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN D Etienne

2. Date of Death Month Day Year: JANUARY 31, 2001

3. Time of Death: 5:15PM

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 435-44-4986

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): 10-21-1931

9. Birthplece (State or Foreign Country): LA

Usual Residenca of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4210 ELDERON AVE

10f. Zip Code: 21215

10g. Citizen ol What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent ol Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Raca - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER

16b. Kind of Business/Industry: TRANSPORTATION

17. Fether's Name (First, Middle, Last): WILLIAM ETIENNE

18. Mother's Neme (First, Middle, Maiden Surname): FRANCES MAYFIELD

19a. Inlorment's Neme/Relationship (Type, Print): FAYE ETIENNE, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 4210 ELDERON AVE, BALTO. MD 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece ol Disposition (Name of cemetery, crematory or other place): BALTIMORE NATIONAL Date: 2-2-01

20c. Location - City or Town, State: BALTIMORE

21. Signature ol Funeral Servica Licensee: ▶ Willie E Howell Jr.

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTIMORE, MD 21207

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in deeth)

a. SEPSIS

Due to (or as e consequence of):

b. INVASIVE SARCOMATOID RENAL CELL CARCINOMA ISD.

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal deeth 3☐ Ectopic pregnancy 4☐ Pregnant et time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ACUTE RENAL FAILURE, RESPIRATORY FAILURE

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy lindings available prior to completion ol cause ol death? 1☐ Yes 2☒ No

25. Was case referred to medical axeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time ol Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, lactory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Phyalcian: To the best ol my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es steted. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete and place, end due to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: 84297

29d. Date signed (Month, Day, Year): 01/31/01

30. Name end address ol person who completed cause ol death (Item 23a) (Type, Print): GEOFFREY N. SKLAR MD 225 GREENE ST 8SNB BALTIMORE MD 21201

State Registrar

31. Date filed (Month, Day, Yeer): FEB 06 2001

32. Registrar's Signature: ▶ Donna G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03113

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JULIAFERN FERRON

2. Date of Death (Month, Day, Year): February 1 2001

3. Time of Death: 12:35 PM

4a. Facility Name (If not institution, give street and number): 7975 CRAIN HWY., S. APT. 116

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 215.52.4679

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 21, 1916

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 7975 CRAIN HWY., S. APT. 116

10f. Zip Code: 21061

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): JOHN L. DOERER

18. Mother's Name (First, Middle, Maiden Surname): CARRIE WARSHAM

19a. Informant's Name/Relationship (Type, Print): ROBERT JAMISON PERSONAL REP.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 419 IRENE DR. GLEN BURNIE, MD 21061

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY, INC.

Date: 3FEB01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: K. GREGORY FINK MO1148

22. Name and Address of Facility: FINK FUNERAL HOME, P.A. 426 CRAIN HWY., S. GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D43677

29d. Date signed (Month, Day, Year): February 1 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Angela Greenup, 301 Hospital Drive, Glen Burnie, MD 21061

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Bonnie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

FERRON JULIAFERN

SM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03114

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAWRENCE WAYNE FLETCHER
2. Date of Death: Month 02 Day 03 Year 2001
3. Time of Death: 7:01 a.m.
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 218-40-5291
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03 07 1943
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL CO.
10c. City, Town or Location: N/A
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7630 WA & B ROAD
10f. Zip Code: 21144
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WAREHOUSE WORKER
16b. Kind of Business/Industry: AUTO PARTS

17. Father's Name (First, Middle, Last): RANDOLPH FLETCHER
18. Mother's Name (First, Middle, Maiden Surname): ADA B. BROWN

19a. Informant's Name/Relationship (Type, Print): ADA GAMCRILL? FRIEND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7630 WA & B ROAD, SEVERN, MARYLAD 21144

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY
Date: 2/10/01
20c. Location - City or Town, State: MERRYDALE, MARYLAND

21. Signature of Funeral Service Licensee: Charles W. Powell
22. Name and Address of Facility: WILLIAM C. BROWN COMMUNITY FUNERAL HOME 1206 W. NORTH AVENUE, BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Pseudomas Pneumnia
Due to (or as a consequence of):
b. Hyperten
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Chronic lymphocytic Leukemia
Due to (or as a consequence of):
d. Emphysema.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [✓] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DALJIT S. SAWHNEY MD
29c. License number: D14136
29d. Date signed (Month, Day, Year): 02-08-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suite 201 Crain Towers 1600 Crain Hwy Glen Burnie Md 21061.

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To be Completed by Funeral Director: permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03115

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Patricia Filip

2. Date of Death: Month 2 Day 3 Year 01

3. Time of Death: 10:57am

4a. Facility Name *(If not institution, give street and number)*: GBMC

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 056-38-8684

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 4-1-50

9. Birthplace *(State or Foreign Country)*: Nwe York

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9 Warren Common

10f. Zip Code: 21030

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: R.N. Coordinator

16b. Kind of Business/Industry: Diversified Service

17. Father's Name *(First, Middle, Last)*: Joseph Jaris

18. Mother's Name *(First, Middle, Maiden Surname)*: Ann P. Lipchuck

19a. Informant's Name/Relationship *(Type, Print)*: Joseph Jaris /Father

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12 Stuyvesant Oval Apt. 1B New York ,New York 10009

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 2/10/01

20c. Location - City or Town, State: Hawthorne N.Y.

21. Signature of Funeral Service Licensee: Curtis F. Shipley

22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore,Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Sepsis	24hrs
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	NON-Hodgkin's Lymphoma	Weeks
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rebecca A. Ludwig MD

29c. License number: D36226

29d. Date signed *(Month, Day, Year)*: 2-4-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Rebecca A. Ludwig MD

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Filip, Patricia

01-0495-033
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

RAMONA RUTH FOSTER
AMENDED ITEMS# 23a, & 27 per M.E. G792 020701 SS

Certificate of Death

Reg. No. 2001 03116

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ramona Ruth Foster

2. Date of Death Month Day Year: JAN. 29, 2001

3. Time of Death: 1746 PM

4a. Facility Name *(If not institution, give street and number)*: GREATER LAUREL BELTSVILLE HOSPITAL

4b. City, Town, or Location of Death: LAUREL

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 578-80-1256

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 44 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 07/20/56

9. Birthplace *(State or Foreign Country)*: Washington D.C.

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8604 Mayaone Street

10f. Zip Code: 20724

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Management Analyst

16b. Kind of Business/Industry: Veterans Administration

17. Father's Name *(First, Middle, Last)*: Henry L. Foster

18. Mother's Neme *(First, Middle, Maiden Surname)*: Virgenia M. Stephens

19a. Intormant's Name/Relationship *(Type, Print)*: Rosemary Tyner-sister

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8604 Mayaone Street, Laurel, Maryland, 20724

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place ot Disposition *(Name of cemetery, crematory or other place)*: Maryland National Cemetery

Date: 02/05/01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Valerie M. Fleck

22. Neme end Address ot Facility: Fleck Funeral Home, Inc. 7601 Sandy Springs Road Laurel, Maryland, 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one ceuse on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth): a. DIABETIC KETOACIDOSIS

Due to (or as a consequence ot):

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Last

b.

Due to (or as a consequenca ot):

c.

Due to (or as a consequenca ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy tindings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical exeminer? 1☒ Yes 2☐ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date ot Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tactory, offica buiiding, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Lawton Cockrum MD

29c. License number: O.C.M.E

29d. Date signed *(Month, Day, Year)*: JAN. 30, 2001

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print): J. Lawton Cockrum MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 0 6 2001

32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03117

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Melvin Louis Fisher

2. Date of Death Month Day Year: February 3, 2001

3. Time of Death: 5:40 PM

4a. Facility Name *(If not institution, give street and number)*: 1916 Wareham Road

4b. City, Town, or Location of Death: Dundalk

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-05-5326

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 17, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1916 Wareham Road

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Letter Carrier

16b. Kind of Business/Industry: Post Office Federal Government

17. Father's Name *(First, Middle, Last)*: Carville Fisher

18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth Perkins

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Ann A. Fisher (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1916 Wareham Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp.

Date: 2/6/2001

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Gregg E. Ruck

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Prostate CA to the Brain

Due to (or as a consequence of):

b. Prostate CA — 10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Diaa Mikhail MD

29c. License number: D51883

29d. Date signed *(Month, Day, Year)*: 2/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Diaa Mikhail 1576 Merritt Blvd, Baltimore, MD 21222

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03118

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert W Frazier Jr.

2. Date of Death Month Day Year: Feb. 1, 2001

3. Time of Death: 11:15am

4a. Facility Name *(If not Institution, give street and number)*: Manor Care Nursing Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-30-7892

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 21, 1934

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2500 W. Belvedere Ave Apt. 405

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* AfroAmerican

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Pantry Pride

17. Father's Name *(First, Middle, Last)*: Robert W. Frazier Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Bosley

19a. Informant's Name/Relationship *(Type, Print)*: Rhonda Lee Frazier/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3909 Clarks Lane Balto., MD 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt Zion Cemetery

Date: February 8, 2001

20c. Location - City or Town, State: Balto. MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only *one* cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO PULMONARY ARREST

Due to (or as a consequence of):

b. END STAGE CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. HTN

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 20215

29d. Date signed *(Month, Day, Year)*: 02/05/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): KARNA CHANDRA S NAIR MD, 4419, FALLS Road BALTIMORE MD 21211

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001

32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03119

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILDRED L. GEAR
2. Date of Death (Month, Day, Year): January 30, 2001
3. Time of Death: 4:45pm
4a. Facility Name (If not institution, give street and number): 3905 Hudson Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 236-14-5430
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 7, 1922
9. Birthplace (State or Foreign Country): W. Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: XX 1☒ Yes 2☐ No
10e. Street and Number: 3905 Hudson Street
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Adolph Taylor
18. Mother's Name (First, Middle, Maiden Surname): Myrtle Pritt

19a. Informant's Name/Relationship (Type, Print): Terry Burkindine-Granddaughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7815 Kavanaugh Road Baltimore, Maryland 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore-Washington Crematory | Date: 2/1/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Elizabeth Selinski
22. Name and Address of Facility: Charles S. Zeiler & Son, Inc. 6224 EAstern Avenue Baltimore, maryland 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Marked pancytopenia with infection + bleeding
Due to (or as a consequence of):
b. acute leukemia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Darry Waterbury, M.D.
29c. License number: DO 9559
29d. Date signed (Month, Day, Year): 1/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): L. WATERBURY, MD JHBMC, 4940 EASTERN AVE., BALT., MD. 21224

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03120

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GENEVIEVE GOEB

2. Date of Death Month: 02 Day: 03 Year: 2001

3. Time of Death: 05:15 AM

4a. Facility Name *(If not institution, give street and number)*: Mercy Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 219-05-1269

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 05-17-21

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD.

10b. County: n/a

10c. City, Town or Location: BALTO., MD.

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 3821 Mt. PLEASANT AVENUE

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Give kind of work done duning most of working life. DO NOT use retired)*: Tavern owner

16b. Kind of Businass/Industry: Self employed My cousins place

17. Father's Name *(First, Middle, Last)*: Joseph Hanus

18. Mother's Name *(First, Middle, Maiden Surnama)*: Elizabeth Clark

19a. Intormant's Name/Relationship *(Type, Print)*: Sandy Giro daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2208 West Geipe Rd. Catonsville, Maryland 21228

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☑ Other *(Specify)* entomb.

20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: Oaklawn

Data: 2/7/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Maria G. Zannino

22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral Hm 263 S. Conkling St., Baltimore, Maryland 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter tha mode of ding, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximata tntarval Between Onset and Death

tmmediate Cause (Final diseasa or condition resulting in death) a. Ruptured Abd Aortic Aneurysm

Dua to (or as a consaquence of): b. Hemorrhage - Shock

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last

Due to (or as a consequance of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese rafarred to medicel examiner? 1☐ Yes 2☐ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of tnjury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of tnjury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and dua to the causa(s) and manner stated.

29b. Signature and title of certifier: ▶ Adam Berger MD

29c. License number: P09788

29d. Dete signed *(Month, Dey, Year)*: 2/3/2001

30. Name and address of person who complated ceuse of death (Item 23a) (Type, Print): Adam Berger 301 St. Paul place, Baltimore, MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 0 6 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03121

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Teresa Melina DeCarlo Grossman

2. Data of Death — Month: February Day: 5 Year: 2001

3. Time of Death: 8:00 am

4a. Facility Name (If not institution, give street and number): 713 Dayspring Drive

4b. City, Town, or Location of Death: Odenton

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 226-82-5797

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 46 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): Jun 18, 1954

9. Birthplace (State or Foreign Country): Washington

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Odenton

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 713 Dayspring Drive

10f. Zip Code: 21113

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): Collega (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Office Manager

16b. Kind of Business/Industry: Heating Ventilation & Air Condition

17. Father's Nama (First, Middle, Last): Vincent Conte

18. Mother's Nama (First, Middle, Maiden Surname): Renee Steinberg

19a. Informant's Name/Ralationship (Type, Print): Ronald Grossman /Husband

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 713 Dayspring Drive, Odenton, MD 21113

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Data: Feb 8 2001

20c. Location - City or Town, Stata: Beltsville, MD

21. Signatura of Funaral Sarvice Licensaa: Laura C. Hardesty

22. Nama and Addrass of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that causad tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Between Onset and Death

Immediata Causa (Final diseasa or condition resulting in daath)

a. METASTATIC BLADDER CANCER — 1 YEAR

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated avants resulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was casa rafarrad to medical examiner? 1☐ Yes 2☑ No

26. Placa of Death (Check only one) — Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☒ Rasidance 8☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one) 1☑ Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐ Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of cartifiar: Ivan Antentijevich, MD

29c. Licensa number: D0055216

29d. Data signed (Month, Day, Year): FEBRUARY 5, 2001

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): IVAN ANTENTIJEVICH, MD JOHNS HOPKINS HOSPITAL, BALTIMORE, MD

State Registrar

31. Data filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signatura: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03122

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Graves

2. Date of Death: Month: Febuary Day: 02 Year: 2001

3. Time of Death: 448 pm

4a. Facility Name (If not institution, give street and number): University of Maryland Cancer Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 228-28-0083

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec.10,1927

9. Birthplace (State or Foreign Country): North Caro.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2239 Orem Avenue

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6TH

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodial Engineer

16b. Kind of Business/Industry: Beth Israel Engineer

17. Father's Neme (First, Middle, Last): James Graves

18. Mother's Name (First, Middle, Maiden Sumama): Louise Brown

19a. Informent's Neme/Reletionship (Type, Print): Deborah Gorman-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Soft Winter Ct. Balto. MD 21117

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Cem.

Date: 02/09

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: Ernest R. Terry, Jr.

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Blact. MD 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pseudomonas Bacteremia — 5 days

Due to (or as a consequence of):

b. Acute Myelogenous Leukemia — 1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End-Stage Renal Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☒ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: P13417

29d. Date signed (Month, Day, Year): February 02, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Summers University Maryland 22 South Greene Street Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Geneva G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03123

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): June Lazenby Green

2. Date of Death: Month February Day 2 Year 2001

3. Time of Death: 1:55 p.m.

4a. Facility Name (If not institution, give street and number): 464 Joyce La.

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 579-07-3747

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 23, 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 464 Joyce Lane

10f. Zip Code: 21012

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Federal Judge

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Eugene Hooper Lazenby

18. Mother's Name (First, Middle, Maiden Surname): Jessica Briggs

19a. Informant's Name/Relationship (Type, Print): John C. Green/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 464 Joyce Lane Arnold, MD 21012

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Metro Crematory, Inc. | Date: 2/3/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MI
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHF
Htn
Renal insufficiency
Cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David Anderson MD

29c. License number: D43236

29d. Date signed (Month, Day, Year): 2/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. David Anderson 2448 Holly Ave. Suite 100 Annapolis Md.

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#8 perFHG792 2/9/2001 EW

Certificate of Death

Reg. No. 2001 03124

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha Gruntkowski

2. Date of Death: Month 01 Day 29 Year 2001

3. Time of Death: 13:35

4a. Facility Name (If not institution, give street and number): Mercy Medical Center 301 Saint Paul Place

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 214-12-0465

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~05-11-20~~ 2-11-20

9. Birthplace (State or Foreign Country): Md

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md

10b. County:

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 435 S. Robinson Street

10f. Zip Code: 21224

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Frank Sieratkowski

18. Mother's Name (First, Middle, Maiden Surname): Mary ?

19a. Informant's Name/Relationship (Type, Print): John Gruntkowski

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 435 S. Robinson St. Baltimore, Md 21224

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stanislaus | Date: 2/3/01

20c. Location - City or Town, State: Baltimore City, Md

21. Signature of Funeral Service Licensee: Charles Kaczorowski

22. Name and Address of Facility: Kaczorowski Funeral Home, PA 1201 Dundalk Ave Baltimore, Md 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Urosepsis — 2 days

Due to (or as a consequence of):

b. decubitus ulcers

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. dementia

Due to (or as a consequence of):

d. diabetes mellitus

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia

coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Daniel E. Weiner MD

29c. License number: P12507

29d. Date signed (Month, Day, Year): 01/29/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daniel E. Weiner, MD 301 St Paul Place, Mercy Medical Center, Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: George B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03125

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Susie Anna Harrison
2. Dete of Deeth — Month: January Day: 28, Year: 2001
3. Time of Death: 336 AM
4a. Facility Neme (If not Institution, give street and number): Joseph Rickie Hospice House
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-34-9443
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 66 Yrs. — If Under 1 Yeer: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/6/1934
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: Md. — 10b. County: N/A — 10c. City, Town or Location: Baltimore — 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2106 Park Ave. — 10f. Zip Code: 21217 — 10g. Citizen of What Country?: U.S.A.

11. Mariel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 6th grade — College (1-4or 5+): N/A
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Cleaning - Laborer
16b. Kind of Business/Industry: House Keeper

17. Father's Name (First, Middle, Last): Abraham Alston
18. Mother's Name (First, Middle, Maiden Surname): Pattie Monley

19a. Informant's Neme/Relationship (Type, Print): Danielle Bowman
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2402 Keyworth Ave. Balto. Md. 21215

20e. Melhod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cem. — Dete: 2/8/2001
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Patricia Betts
22. Name end Address of Facility: Betts Funeral Home 1129 N. Caroline Street Balto. Md. 21213

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. — Approximale Interval Between Onset and Death

Immediate Cause (Finai disease or condition resulting in death): a. Carcinoma of colon with mets — 1 year

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, feclory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: John K. Payne M.D.
29c. License number: D13012
29d. Dete signed (Month, Day, Year): Jan 29, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Payne 6565 N. Charles St 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Jeanne B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

January 28, 2001 3:36 PM

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Susie Harrison

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03126

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Herman W Happel
2. Date of Death Month / Day / Year: January 31 2001
3. Time of Death: 00:05 am
4a. Facility Name *(If not institution, give street and number)*: Baltimore VA Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216 18 4923
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 12, 1922
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 325 West Arundel Road
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Pipe Fitter
16b. Kind of Business/Industry: FMC

17. Father's Name *(First, Middle, Last)*: William Happel
18. Mother's Name *(First, Middle, Maiden Surname)*: Madeline Dew

19a. Informant's Name/Relationship *(Type, Print)*: Thelma Happel / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 325 West Arundel Road Baltimore, Maryland 21225

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Bayview Crematory, Inc.
Date: 2/5/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Sharron Liggett
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 12 days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease
Abdominal Aortic Aneurysm
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shelley L. Snodgrass MD
29c. License number: P12492
29d. Date signed *(Month, Day, Year)*: January 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shelley Snodgrass MD Baltimore VA Medical Center 10 N. Greene St. Baltimore, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001
32. Registrar's Signature: Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03127

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy M. Hayes

2. Date of Death Month / Day / Year: February 5th, 2001

3. Time of Death: 1:35 PM

4a. Facility Name *(If not Institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218 09 1775

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 3, 1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1736 Poplar Ridge Road

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12th / College (1-4or 5+):

16a. Decedent's Usuet Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: Martin T. McHale

18. Mother's Name *(First, Middle, Maiden Sumeme)*: Della Fox

19a. Informent's Neme/Relationship *(Type, Print)*: Edward Hayes Jr. / Son

19b. Meiting Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1736 Poplar Ridge Road Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Memorial Park

Dete: 2/8/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funaral Service Licensee: Donna M Yaminoushi

22. Name end Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in deeth)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b.

Due to (*or* as e consequence of):

c.

Due to (*or* as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner steted.

29b. Signature and title of certifier: MD

29c. License number: D48006

29d. Dete signed *(Month, Dey, Year)*: February 5th, 2001

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): KOFI BOATENG, 301 Hospital Dr., Glen Burnie, MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 0 6 2001

32. Registrar's Signeture: Geneva B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23a perPHYG792 2/6/2001 EW

Certificate of Death

Reg. No. 2001 03128

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): DORA HUTCHINSON

2. Dete of Death — Month: Jan; Dey: 28; Yeer: 2001

3. Time of Death: 9:37 a.m.

4e. Fecility Neme (If not institution, give street and number): Emerald Estates Assisting Living

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 219-28-1430

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 96 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): Dec. 7,1904

9. Birthplece (Stete or Foreign Country): Kentucky

Usuel Residence of Decedent

10e. Stete: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3855 Greenspring Avenue

10f. Zip Code: 21211

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No — Specify:

14. Race - Americen Indien, Black, White, etc. — Specify: BLACK

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 12th; College (1-4or 5+): +

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Counselor

16b. Kind of Business/Industry: Baltimore City Public Schools

17. Fether's Neme (First, Middle, Last): Wesley Hughes

18. Mother's Neme (First, Middle, Meiden Surneme): Blanche

19e. Informent's Name/Reletionship (Type, Print): Robin W. Wood-Niece

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1104 Bryn Mawr RD. Balto. MD 21210

20e. Method of Disposition: 1☒ Burieł 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Arbutus Mem. Pk. Cem.

Dete: 02/03

20c. Location - City or Town, Stete: Baltimore, MD

21. Signeture of Funerel Service Licensee: ▶ Herbert E. Nutter

22. Neme end Address of Feciliity: Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Final diseese or condition resulting in deeth)

e. Cardiopulmonary Arrest

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

b. CONGESTIVE HEART FAILURE

Due to (or es e consequence of):

c. ~~Congestive Heart Failure~~ ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es e consequence of):

d. ~~Arteriosclerotic Cardiovascular Disease~~

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. **Did tobecco use contribute to the cause of deeth?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netureł 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medicel Exeminer:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ Howard B. Eleen M.D.

29c. License number: D21680

29d. Dete signed (Month, Dey, Yeer): 1/30/01

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): 6717 PARK HEIGHTS AVENUE 21215

State Registrar

31. Dete filed (Month, Day, Year): FEB 0 6 2001

32. Registrer's Signeture: ▶ Jeneva B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23a perPHYG792 2/6/2001 EW

Certificate of Death

Reg. No. 2001 03129

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY J. HARPER

2. Date of Death — Month: JANUARY Day: 19 Year: 2001

3. Time of Death: 1:50 AM

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212 28 0062

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 27, 1932

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4400 Belle Grove Road

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Joseph Patrick O'Donovon

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth (not available)

19a. Informant's Name/Relationship (Type, Print): Arthur J. Harper Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4400 Belle Grove Road Baltimore, Maryland 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 1/22/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Bramhorst

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CORONARY ARTERY DISEASE ~~RESPIRATORY FAILURE~~	ONE HOUR
Due to (or as a consequence of): b.	CARDIAC ARREST	ONE HOUR
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

TRANSIENT ISCHEMIC ATTACK

RHEUMATOID ARTHRITIS.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sumeet Sawhney MD.

29c. License number: P-14121

29d. Date signed (Month, Day, Year): JANUARY 19 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUMEET SAWHNEY HARBOR HOSPITAL CENTER

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 12 PER F.H. G792 2-14-01 WR.
Amend Item#12,13 perDVRG792 2/15/2001 EW

Certificate of Death

Reg. No. 2001 03130

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
Melvin		Houck	February 1 2001	1832

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Hospital	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
177-24-2031	1☒M 2☐F	70 Yrs.			March 13,1930	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
PA	Fulton	Needmore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5202 Black Bear Road	17238	United States

11. Meritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1952-1954	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 Years		Correction Officer	Baltimore City

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Roy Melvin Houck	Viola Jensen

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. JoAnn M. Houck (Wife)	5202 Black Bear Road Fulton, PA 17238

20e. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stata
1☐Burial 2☒Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hilltop Service Corp.	2/6/2001	Towson, Maryland

21. Signature of Funeral Service Licensee: Chad W. Fuller

22. Name end Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that ceuse the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ischemic cardiomyopathy	2 years
Due to (or as a consequence of):	b. coronary artery disease	unknown
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Diabetes Mellitus

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Wes cese referred to medicel examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
Aimee Zaas MD	RES. 000	February 01, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Johns Hopkins Hospital 601 N. Wolfe Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 0 6 2001	Geneva D. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03131

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Philip D. Harbaugh

2. Date of Death (Month, Day, Year): February 2 2001

3. Time of Death: 09:25 PM

4a. Facility Name (If not institution, give street and number): Oak Crest Village Care Center

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-03-0784

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 28, 1905

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8800 Walther Blvd.

10f. Zip Code: 21234

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Store Fixtures

17. Father's Name (First, Middle, Last): Dean C. Harbaugh

18. Mother's Name (First, Middle, Maiden Surname): Theresa Kroeger

19a. Informant's Name/Relationship (Type, Print): Sandra Harbaugh Justis/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 327 Old Trail Road Baltimore, MD 21212

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens

Date: Feb. 5, 2001

20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Michael J. Flagle

22. Name and Address of Facility: Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer — 7 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the ceuse(s) and mannar steted.

29b. Signature and title of certifier: MD

29c. License number: D74073

29d. Date signed (Month, Day, Year): February 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary Applebaum MD 701 Maiden Choice Lane 21228

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Harbaugh, Philip

01-0560-510
jhm
DAVID ANDREW
HARRIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23a,27,& 28a-f per MF Certificate of Death

Reg. No. 2001 03132

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
DAVID ANDREW HARRIS	FEBRUARY 02, 2001	04:40 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
819 BROOKS LANE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-84-6745	X 1 M 2 F	38 Yrs.			01-05-1963	BALTIMORE

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
819 BROOKSLANE	21217	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		NURSE	NURSING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ANDREW HARRIS	MARY BELL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ANDREW HARRIS, FATHER	819 BROOKS LANE, BALTO. MD 21217

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Mount Zion	02-07-01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Willie E. Howell	HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS AND PERITONITIS FROM BOWEL PERFORATION FOLLOWING MOTOR VEHICLE COLLISION IN ASSOCIATION WITH COCAINE USE AND NARCOTIC INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 X Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 X Yes 2 No

28. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 X Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 X Could not be determined	found: 2-2-01	found: 4:30 a M	1 Yes 2 X No	unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
found at home	819 Brooks Ln, Balt, MD

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Pertaner, MD	OCME	FEBRUARY 02, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 05 2001	Denise G Coates

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#5 PER INF G823 9/15/03 JC

Certificate of Death

Reg. No. 2001 03133

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GRACE LOCKE HARVEY

2. Date of Death: Month FEBRUARY Day 4 Year 2001

3. Time of Death: 12:05PM

4a. Facility Name (If not institution, give street and number): 2 LINDSAY LANE

4b. City, Town, or Location of Death: RUXTON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: ~~216-46-1585~~ 216-16-6194

6. Sex: 1☐ M XX F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09-18-1922

9. Birthplace (State or Foreign Country): TEXAS

Usual Residence of Decedent

10a. State: MD.

10b. County: BALTIMORE

10c. City, Town or Location: RUXTON

10d. Inside City Limits: 1☐ Yes XX No

10e. Street and Number: 2 LINDSAY LANE

10f. Zip Code: 21212

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12):

College (1-4or 5+): 4 YEARS

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): JOHN ROBINSON LOCKE

18. Mother's Name (First, Middle, Maiden Surname): GRACE WALKER

19a. Informant's Name/Relationship (Type, Print): F. BARTON HARVEY, III (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 MIDVALE ROAD, BALTIMORE, MARYLAND, 21210

20a. Method of Disposition: 1☐ Burial XX Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MOUNT CREMATORY

Date: 02/05/2001

20c. Location - City or Town, Stete: BALTIMORE, MD., 21202

21. Signature of Funeral Service Licensee: ▶ R. D. Ruth

22. Name end Address of Facility: HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD, BALTIMORE, MARYLAND, 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Alhzeimer Disease — >3yrs

Due to (or as a consequenca of):

b. CVA — >2mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or as a consequenca of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes XX No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes XX No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home XX Residenca 6☐ Other (Specify)

27. Manner of Death: XX Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D0053654

29d. Date signed (Month, Day, Year): FEBRUARY 5, 2001

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): YAO-YAO M.D. 6500 N. CHARLES ST. EAST PAVILLION TOWSON, MD. 21204.

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03134

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward Holmes
2. Date of Death Month Day Year: January 31, 2001
3. Time of Death: 1937
4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 207-20-8670
6. Sex: 1☐M 2☐F
7. Age *(In yrs. last birthday)*: 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 1/7/1923
9. Birthplace *(State or Foreign Country)*: South Caroline

Usual Residence of Decedent

10a. Stete: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 1518 N. Caroline St.
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Merital Stetus: 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever In U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - Americen Indian, Bleck, White, etc. Specify: Black

15. Decedent's Edcetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 7th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Security guard
16b. Kind of Business/Industry: Baltimore civic center

17. Father's Neme *(First, Middle, Last)*: Javare Holmes
18. Mother's Neme *(First, Middle, Maiden Sumame)*: olee Holmes

19a. Informant's Neme/Reletionship *(Type, Print)*: Rachel Holmes-wife
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1518 N. Caroline st. Baltimore, maryland 21213

20a. Method of Disposition: 1☑Buriel 2☐Cremetion 3☐Removal from Stete 4☐Donetion 5☐Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Garrison forest Cemetary
Dete: 2/7/2001
20c. Location - City or Town, Stete: Baltimore, maryland
21. Signature of Funeral Service Licensee: Geoffrey Miller
22. Neme end Address of Fecility: Miller's Metropolitan Chapel 1639 N. Broadway 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in death):
a. Asystole — 10 minutes
Due to (or es e consequence of):
b. Prostate Cancer — 2 years

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Last
Due to (or as a consequence of):
c.
Due fo (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medicef examiner? 1☐Yes 2☒No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐Inpatient 2☒ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*
27. Menner of Death: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, tarm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner es stated. 2☐**Medical Examiner:** On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner steted.
29b. Signeture and title of certifier: MD
29c. License number: RES-000
29d. Dete signed *(Month, Day, Year)*: February 2, 2001
30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print): 600 N. Wolfe Street. Baltimore, MD 21287

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 0 6 2001
32. Registrer's Signeture:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03135

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GERALDINE JEFFERS
2. Date of Death (Month, Day, Year): FEDRUARY 3, 2001
3. Time of Death: 11:15 AM
4a. Facility Name (If not institution, give street and number): MARYLAND GENERAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 244-50-2938
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08 28 1937
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5535 MIDWOOD AVENUE
10f. Zip Code: 21212
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COOK
16b. Kind of Business/Industry: BAKERY

17. Father's Name (First, Middle, Last): JOHN PIERCE
18. Mother's Name (First, Middle, Maiden Surname): MANNIE BELL MORRIS

19a. Informant's Name/Ratiationship (Type, Print): CATHY STATON/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5535 MIDWOOD AVE, BALTIMORE, MARYLAND 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY
Date: 2/10/01
20c. Location - City or Town, State: LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee: Charles N. Brull
22. Name and Address of Facility: WILLIAM C. BROWN COMMUNITY FUNERAL HOME, 1206 W. NORTH AVENUE, BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of): b. FUNGEMIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: 89371
29d. Date signed (Month, Day, Year): 2-3-2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): LINDA GEORGE M.D. C/O MARYLAND GENERAL HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Geraldine Jeffers
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03136

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CATHERINE V. JOHNSTON
2. Date of Death Month/Day/Year: FEBRUARY 5, 2001
3. Time of Death: 11:47 AM
4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214 22 0791
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 20, 1926
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4111 Highland Avenue
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Florist
16b. Kind of Business/Industry: Flower Shop

17. Father's Name *(First, Middle, Last)*: Stanley Janaska
18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Bleemke

19a. Informant's Name/Relationship *(Type, Print)*: George Johnston / Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4111 Highland Avenue Baltimore, Maryland 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Holy Cross Cemetery
Date: 2/9/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Shannon M Liggett
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	2 WEEKS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. RESPIRATORY FAILURE - PULMONARY EDEMA	2 WEEKS
Due to (or as a consequence of):		
	c. ACUTE RENAL FAILURE	1 WEEK
Due to (or as a consequence of):		
	d. METABOLIC ENCEPHALOPATHY	1 WEEK

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: LIVER CIRRHOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: RES-000
29d. Date signed *(Month, Day, Year)*: FEBRUARY 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RISHI SAWHNEY, MD HARBOR HOSPITAL, 3001 S. HANOVER ST. BALTIMORE, MD 21225

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03137

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DEONTE JACOBS
2. Date of Death (Month, Day, Year): FEBRUARY 4, 2001
3. Time of Death: 03:15
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-31-2745
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 10 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jul. 6, 1990
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 318 N. Robinson Street
10f. Zip Code: 21224
10g. Citizen of What Country? USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐Yas 2☒No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 5th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: Highlandtown Elementary School

17. Fathar's Nama (First, Middla, Last): Albert Jacobs
18. Mother's Name (First, Middle, Maiden Sumama): Towanda J. Bessick

19a. Informent's Name/Ralationship (Type, Print): Sean C. Davis-Stepfather
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 318 N. Robinson St. Balto. MD 21224

20a. Mathod of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Othar (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Mem, Pk. Cem.
Date: 02/06
20c. Location - City or Town, State: Baltimore, Maryland

21. Signatura of Funaral Service Licensee: Ernest R. Tenney Jr
22. Nama and Address of Facility: Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart tailura. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in death):
a. CARDIOGENIC SHOCK OF UNKNOWN ETIOLOGY — 1 DAY
Due to (or as a consequence of):

Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disaase or Injury thet initiated avents resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.
STATUS EPILEPTICUS
LEFT INGUINAL BUBOE
RHABDOMYOLYSIS

23b. Did tobecco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Wes casa ratarrad to medical examinar? 1☐Yas 2☑No

26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Cartifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifiar: Will MD
29c. License number: RES-000
29d. Data signed (Month, Day, Year): FEBRUARY 4, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM STOTZ JOHNS HOPKINS HOSPITAL - PICU BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03138

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Katherine Kettering

2. Date of Death: Month 02 Day 04 Year 01

3. Time of Death: 10A

4a. Facility Name (If not institution, give street and number): Cromwell Nursing Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-18-5232

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): January 10, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 1 Overbrook Drive

10f. Zip Code: 21014

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th Grade

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Paul Burkhardt

18. Mother's Name (First, Middle, Maiden Surname): Martha Paige

19a. Informant's Name/Relationship (Type, Print): Ann Griffin Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1713 Redwood Avenue Baltimore, Maryland 21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corporation

Date: 02/06/01

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Christina L. Hilton

Christina L. Hilton

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Duramen CA — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ____

Due to (or as a consequence of):

c. ____

Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHF

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Martha C. Raymundo MD

29c. License number: 054518

29d. Data signed (Month, Day, Year): 2/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martha C. Raymundo 3007 E Northern Parkway Baltimore MD 21214

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03139

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: M. Angele Klein
2. Date of Death (Month, Day, Year): February 3, 2001
3. Time of Death: 6 PM
4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-01-6091
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 23, 1918
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4311 Newport Avenue
10f. Zip Code: 21211
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Martin Marietta Company

17. Father's Name *(First, Middle, Last)*: Chester Sipple
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary A. Burns

19a. Informant's Name/Relationship *(Type, Print)*: Harry B. Klein Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4311 Newport Avenue Baltimore, MD 21211

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery
Date: 2/7/2001
20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: Harry H. Carpenter
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Stroke — 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Psoriatic Arthritis
Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☑ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William D. McConnell MD
29c. License number: D#2129
29d. Date signed *(Month, Day, Year)*: Feb. 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William D. McConnell 500 W. University Baltimore

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 0 6 2001
32. Registrar's Signature: Geneva B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03140

HARRY KLAFF - FEBRUARY 1, 2001 @ 2:45AM
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
HARRY	KLAFF	FEBRUARY 1, 2001	2:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOSPICE OF BALTIMORE GILCHRIST CENTER	TOWSON	BALTIMORE

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-16-2690	X 1 M 2 F	91 Yrs.			DEC. 22, 1909	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	LUTHERVILLE	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1300 YORK ROAD - SUITE 180	21093	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		PROPRIETOR	WHOLESALE

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
ISAAC	KLAFF	MINNIE	SHERR

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BEVERLY FREELAND / DAUGHTER	P.O. BOX 422 - BROOKLANDVILLE, MD 21022

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	BETH EL MEMORIAL PARK	2/4/01	RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: ▶ Jay Allen Lewis

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration pneumonia	8 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: squamous cell CA of parotid gland

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ W. Anthony Riley, MD	D25205	February 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley UBMC 6701 N. Charles St. Balto. Md 21204

State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature
	FEB 05 2001	▶ Donna B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03141

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JACQUELINE LLOYD
2. Data of Death Month/Day/Year: FEBRUARY 4, 2001
3. Time of Death: 5:10 PM
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-30-3854
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 17, 1935
9. Birthplece (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Windsor Mill
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6814 Windsor Mill Road
10f. Zip Code: 21244
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Merried 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Wes Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Year or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 10; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Homemaker
16b. Kind of Businass/Industry: Own Home

17. Father's Name (First, Middle, Last): Edward Tasker
18. Mother's Neme (First, Middle, Meiden Surname): Margaret DeWitt

19a. Informent's Neme/Reletionship (Type, Print): Paulette Palek/Daughter
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 5810 Melville Road Sykesville, MD 21784

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other pleca): Carroll Cremation, Inc.
Date: 2/6/2001
20c. Location - City or Town, State: Hampstead, MD

21. Signeture of Funerel Service Licensee: Jeffrey N. Zumbrun
22. Name end Address of Facility: J.N. Zumbrun F.H. & Monument Co. 6028 Sykesville Road Eldersburg, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immedieta Causa (Final disease or condition resulting in death):
a. CHF
Due to (or es e consequence of):
b. Acute Respiratory Failure
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest
Due to (or es a consequence of):
c. Sepsis
Due to (or as a consequence of):
d. MRSA Pneumonia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
morbid obesity; HTN
CAD
COPD

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause ot deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Piece of Deeth (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, tectory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end manner es stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signeture and title of certifier: MD
29c. License number: D44505
29d. Dete signed (Month, Day, Year): February 4, 2001

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): A.J. IMPERIAL, Jr. MD — NWHC

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03142

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frances Antonette Lewis

2. Date of Death Month Day Year: February 5, 2001

3. Time of Death: 12:25 AM

4a. Facility Name *(If not institution, give street and number)*: Futurecare Nursing Home

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-07-0318

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 14, 1906

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 331 Gatewater Court #103

10f. Zip Code: 21060

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 yr's | College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bookkeeper

16b. Kind of Business/Industry: Lumber Company

17. Father's Neme *(First, Middle, Last)*: Frank Ruck

18. Mother's Name *(First, Middle, Meiden Surname)*: Anna Marie Kemp

19a. Informant's Name/Reiationship *(Type, Print)*: Patricia A. Abramson - Daughter

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 331 Gatewater Court #103 Glen Burnie, MD 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Holy Redeemer

Dete: 2/7/01

20c. Location - City or Town, State: Baltimore, MD

21. Signeture of Funerel Service Licensee: ▶ Paul L. Hartsock Jr.

22. Name and Address of Facility: Baltimore, MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — days

Due to (or es e consequence of):

b. Alzheimer's dementia — years

Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: ▶ MD

29c. License number: D-50725

29d. Date signed *(Month, Dey, Year)*: 2/5/01

30. Name end addrees of person who completed ceuse of death (Item 23a) (Type, Print): Jennifer Riedinger 479 Jumpers Hole Rd Severna Park MD 21146

State Registrar

31. Date filed *(Month, Dey, Year)*: FEB 0 6 2001

32. Registrer's Signature: ▶ B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0447-003

GLENN McCARTHY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23a,27,& 28a-f G792 021401 SS

Certificate of Death

Reg. No. 2001 03143

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Glenn James McCarthy

2. Date of Death (Month, Day, Year): JANUARY 26, 2001

3. Time of Death: 7:05P.M.

4a. Facility Name (If not institution, give street and number): 1420 S.CRAIN HWY

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 028-50-1109

6. Sex: [X] M [ ] F

7. Age (In yrs. last birthday): 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 18, 1960

9. Birthplace (State or Foreign Country): MA

Usual Residence of Decedent

10a. State: FL

10b. County:

10c. City, Town or Location: Clearwater

10d. Inside City Limits: [ ] Yes [X] No

10a. Street and Number: 2639 Teakwood Drive

10f. Zip Code: 33764

10g. Citizen of What Country: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Engineer

16b. Kind of Business/Industry: Aerospace

17. Father's Name (First, Middle, Last): Edward J. McCarthy

18. Mother's Name (First, Middle, Maiden Surname): Madeline Pezda

19a. Informant's Name/Relationship (Type, Print): Melanie McCarthy / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 51 Beebe Road, Wilbraham MA 01095

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stanislaus Cem.

Date: February 1, 2001

20c. Location - City or Town, State: Chicopee, MA

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ACUTE ETHANOL AND NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably [X] Unknown

24a. Was an autopsy performed? [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify): SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined

28a. Date of Injury (Month, Day, Year): found: 1-26-01

28b. Time of Injury: found: 4:55 PM

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 1420 S. Crain Hgwy Glen Burnie, MD

29e. Certifier (Check only one)

1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J Chute M

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chute M 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03144

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY MACK

2. Date of Death: Month February Day 4th Year 2001

3. Time of Death: 2:05 AM

4a. Facility Name (If not institution, give street and number): Northwest Hospital Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 484-26-2177

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 9, 1916

9. Birthplace (State or Foreign Country): IA

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Pikesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 32 Tentmill Lane Apt. G

10f. Zip Code: 21208

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Interior Decorator

16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Lee W. Forman

18. Mother's Name (First, Middle, Maiden Surname): Martha Leffler

19a. Informent's Name/Relationship (Type, Print): Roberta Sarubin /Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6901 Jones View Drive Apt. 3 B, Baltimore, MD

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: 2-6-01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Laura C. Hardesty

22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Probable Malignant arrhythmia

Due to (or as a consequence of):
b. Probable Asperation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Bilateral Pleural Effusion.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Thrombosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jogindra P Mehta M.D

29c. License number: D0041410

29d. Date signed (Month, Day, Year): February 04th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOGINDER P Mehta NORTH WEST HOSPITAL CENTER RANDALLTOWN MD 21133.

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03145

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thelma J. C. Miller

2. Date of Death (Month, Day, Year): February 5, 2001

3. Time of Death: 11:45 AM

4a. Facility Name (If not institution, give street and number): Hospice Of Baltimore Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-07-1027

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8-22-1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8800 Walther Blvd. #4312

10f. Zip Code: 21234

10g. Citizen of What Country? U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: City Of Baltimore

17. Father's Name (First, Middle, Last): Ernest McMann

18. Mother's Name (First, Middle, Maiden Surname): Susan Seitz

19a. Informant's Name/Relationship (Type, Print): Mr. Donald B. Klima (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1004 Green Acre Road, Towson, Maryland 21204

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: 2-8-01

20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: ▶ Walter S Brady Jr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ W. Bethany Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): February 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: ▶ Jennifer D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Miller, Thelma February 5, 2001 1145 Am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03146

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Marilyn Martin	February 1 2001	2:30 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
420 Old Riverside Road	Baltimore	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213 22 4535	1☐M 2☒F	74 Yrs.			Sept. 26, 1926	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
420 Old Riverside Road	21225	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Phone Operator	C & P Telephone

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jesse Moore	Edna Emrick

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ernest Martin / Son	7405 Merrimusic Circle Severn, Maryland 21144

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Sunset Memorial Cem.	Feb. 5, 2001	Cumberland, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Donna M Zaminowski	Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary Embolism	hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple Myeloma

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D31557	Febrny 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell Parker 3001 S Hanover St, Baltimore, Md. 21225

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 0 6 2001	Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03147

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ezaltina B. Moniz

2. Date of Death — Month: February Day: 04 Year: 2001

3. Time of Death: 9:45 AM

4a. Facility Name *(If not institution, give street and number)*: Stella Maris at Mercy Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 010 01 8768

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: March 24, 1917

9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 126 East Churchill Street

10f. Zip Code: 21230

10g. Citizen of Whet Country?: U.S.

11. Marital Status: 1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assistant

16b. Kind of Business/Industry: Statistical

17. Father's Name *(First, Middle, Last)*: William B. Moniz

18. Mother's Name *(First, Middle, Maiden Sumame)*: M. Theolinda Souza

19a. Informant's Name/Relationship *(Type, Print)*: William Barges / Nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 126 East Churchill Street Baltimore, Maryland 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. John Cemetery

Dete: 2/9/01

20c. Location - City or Town, State: Newbedford, Mass.

21. Signature of Funeral Service Licensee: Garrett M Liggett

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

a. Stroke — 1 month

Due to (or as e consequence of):

b. Parkinsonism — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other signiftcant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medicat examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)* STELLA MARIS AT MERCY

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or Investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D38675

29d. Date signed *(Month, Day, Year)*: 2/5/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOEL MESHULAM 301 ST PAUL PL SUITE 605 BALTIMORE MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001

32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

01-0467-001
ANITA MACHOLIN
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03148

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anita Lynne Machlin

2. Date of Death: Month JANUARY Day 27 Year 2001

3. Time of Death: 11:55 A

4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 214-60-2572

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 18, 1952

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15817 Thompson Road

10f. Zip Code: 20904

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Federal Agency

17. Father's Neme (First, Middle, Last): Elwin Lee Strosnider

18. Mother's Name (First, Middle, Maiden Surname): Grace Rayola McIntyre

19a. Informant's Neme/Retetionship (Type, Print): Rayola Hill/Sister

19b. Meiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 13933 Wayside Drive Clarksville, MD 21029

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other place): Metro Crematory Inc.

Date: 2-2-01

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Edneral Service Licensee: Edward A. Gregorchik

22. Name and Address of Feciity: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Finel diseese or condition resulting in deeth)

a. MULTIPLE INJURIES

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yaa 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Neturel 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year): 1/27/01

28b. Time of Injury: 10:20 A M

28c. Injury et Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Passenger involved in MOTOR VEHICLE ACCIDENT

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State): ROUTE 219 KEYSER'S RIDGE, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the ceuse(s) end manner as stated. 2☒ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete and piece, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier: J. M. Titus

29c. License number: O.C.M.E

29d. Dete signed (Month, Day, Year): JANUARY 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): FEB 0 6 2001

32. Registrer's Signature: Barbara B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0606-510
jhm
JESSIE
MERRITT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03149

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JESSIE H. MERRITT	FEBRUARY 04, 2001	04:00 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
406 EVESHAM AVENUE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-16-3253	1☐M 2☒F	84 Yrs.			07/12/1916	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
406 EVESHAM AVE	21212	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12YRS		HOUSEWIFE	HOMEMAKER

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLES P. HENRY	LAURA POTTS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
KATHERINE G. CONGDON(DAUGH)	5216 BEECH RIDGE RD. NASHVILLE,TN. 37221

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MEADOWRIDGE MEM.	02/07/2001	HOWARD CO.,MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
William R. Lane III	HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. _____

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) SCENE

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stephen S. Radentz, MD	OCME	FEBRUARY 04, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 06 2001	Penny B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Attending Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03150

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Moskowitz
2. Date of Death (Month, Day, Year): February 2, 2001
3. Time of Death: 0449
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 205-20-1486
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 7, 1929
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3700 CROSSLEIGH COURT
10f. Zip Code: 21133
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ELECTRICAL ENGINEER
16b. Kind of Business/Industry: ENGINEERING

17. Father's Name (First, Middle, Last): BENJAMIN MOSKOWITZ
18. Mother's Name (First, Middle, Maiden Surname): BETTY WEINER

19a. Informant's Name/Relationship (Type, Print): DIANE MOSKOWITZ / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3700 CROSSLEIGH COURT - RANDALLSTOWN, MD 21133

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE HEBREW CEMETERY
Date: 2/4/01
20c. Location - City or Town, State: REISTERSTOWN, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Brooks, MD
29c. License number: D0055459
29d. Date signed (Month, Day, Year): February 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03151

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PRENTICE LEE NOCK
2. Date of Death (Month, Day, Year): FEBRUARY 2 2001
3. Time of Death: unknown
4a. Facility Name (If not institution, give street and number): 5700 PRINCE GEORGE STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CO

Funeral Director

5. Social Security Number: 213-30-2919
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 25, 1933
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5700 PRINCE GEORGE STREET
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 53/55
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): POSTAL CARRIER
16b. Kind of Business/Industry: U.S. POSTAL SERVICE

17. Father's Name (First, Middle, Last): BRANTLEY LEE NOCK
18. Mother's Name (First, Middle, Maiden Surname): LUCINDA CONQUEST

19a. Informant's Name/Relationship (Type, Print): Lucinda Nock/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5700 Prince George St., Baltimore, Maryland 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST
Date: 2-8-01
20c. Location - City or Town, State: OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee: Charles H. Powell
22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA, 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia, community acquired — 2 weeks
Due to (or as a consequence of):
b. Prostate cancer with metastasis — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Anemia, Thrombocytopenia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Benjamin S. Lee, M.D., Physician
29c. License number: D52544
29d. Data signed (Month, Day, Year): Feb 2, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Benjamin S. Lee, M.D., 700 Geipe Rd #204, Catonsville, MD 21228

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03152

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Selina Kathy Neal

2. Date of Death Month / Day / Year: FEB. 1, 2001

3. Time of Death: 2:30pm

4a. Facility Name *(If not institution, give street and number)*: 1513 Lanflair Road

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 103-44-4630

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 5, 1953

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1513 Lanflair Road

10f. Zip Code: 21221

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): UNK. / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeping

16b. Kind of Business/Industry: Domestic

17. Father's Name *(First, Middle, Last)*: Raymond Neal

18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Killingsworth

19a. Informant's Name/Relationship *(Type, Print)*: Tyrone Neal/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1513 Lanflair Road Essex, MD 21221

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc.

Date: 2-3-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Liver Disease

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ETOH

Due to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D43725

29d. Date signed *(Month, Day, Year)*: 2/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ MAHMOOD 201-109 Buck River Neck Road Baltimore MD 21221

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001

32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03153

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JEANNETTE S. OVERTON
2. Date of Death (Month, Day, Year): JAN. 31 2001
3. Time of Death: 6:20pm
4a. Facility Name (If not institution, give street and number): MANOR CARE ROLAND PARK
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-44-6702
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05/26/1910
9. Birthplace (State or Foreign Country): WASH.,D.C.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4669 FALLS RD.
10f. Zip Code: 21209
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12YRS | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OFFICE WORK
16b. Kind of Business/Industry: U.S. GOVERNMENT
17. Father's Name (First, Middle, Last): JOHN B. HUDSON
18. Mother's Name (First, Middle, Maiden Surname): MARIE L. DIOLOT
19a. Informant's Name/Relationship (Type, Print): LAWRENCE LEYKING(NEPHEW)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14150 ARBOLITOS DR. POWAY,CA. 92064.
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MOUNT CREMATORY | Date: 02/02/2001
20c. Location - City or Town, State: BALTO.,MD.
21. Signature of Funeral Service Licensee: William C. Lawton II
22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Generalized Atherosclerosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sheldon Goldgeier M.D.
29c. License number: DO 2397
29d. Date signed (Month, Day, Year): 2/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHELDON GOLDGEIER M.D. 1838 GREEN TREE RD PIKESVILLE, MD. 21209.

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Jenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03154

Name: Robert H. Powers
Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Robert Holman Powers
2. Date of Death Month Day Year: February 2, 2001
3. Time of Death: 2:35am
4a. Facility Name *(If not institution, give street and number)*: VAMHCS Fort Howard Division
4b. City, Town, or Location of Death: Fort Howard
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218187476
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthdey)*: 75 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 23, 1925
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore Highlands
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2811 Georgia Ave.
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: 1943-1946
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done duning most of working life. DO NOT use retired)*: Letter Carrier
16b. Kind of Business/Industry: Post Office

17. Fether's Neme *(First, Middle, Last)*: Stewart Holman Powers
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Louise Belle Parker

19a. Informent's Neme/Reletionship *(Type, Print)*: Rosalie Helen Powers, Wife
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 2811 Georgia Ave. Baltimore, MD. 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Crownsville MD Veteran's Cemetery — Dete: 2-5-01
20c. Location - City or Town, Stete: Elkridge, MD

21. Signeture of Funerel Service Licensee: Rebecca Robinson
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth): e. Pneumonia — 2weeks

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last:
b.
Due to (or as e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.: Alzheimers Dementia; Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end pleca, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Marcos B. Galicia, M.D.
29c. License number: D0015698
29d. Dete signed *(Month, Day, Year)*: Feb. 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marcos B. Galicia, MD 9600 North Point Rd Fort Howard, Maryland 21052

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 06 2001
32. Registrar's Signature: Bernard B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03155

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sidney Leroy Pierce
2. Date of Death Month: JANUARY Day: 29 Year: 2001
3. Time of Death: 8 PM
4a. Facility Name (If not institution, give street and number): Doctors Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 704.05.8028.A
6. Sex: 1 M 2 F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 3, 1919
9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1 Yes 2 No
10e. Street and Number: 10302 Buena Vista Avenue
10f. Zip Code: 20706
10g. Citizen of What Country?: United States

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Supervisor
16b. Kind of Business/Industry: Construction

17. Father's Neme (First, Middle, Last): Walter Thaddeus Pierce
18. Mother's Name (First, Middle, Maiden Sumame): Arena Montgomery Pierce

19a. Informant's Name/Relationship (Type, Print): Helen Coley Pierce
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10302 Buena Vista Avenue Lanham Maryland 20706

20a. Method of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Washington National Cem.
Date: Feb. 3rd
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Fcheral Service Licensee: CC0348
22. Name and Address of Facility: Latney's Funeral Home 20011 3831 Georgia Avenue, N. W. Washington, D. C.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, auch as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Deeth

Immediate Causa (Final disease or condition resulting in death): a. Metastatic prostate Cancer

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or es a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Deaths Mellitus

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was en autopsy performed? 1 Yes 2 No
24b. Were autopsy findings available prior to completion of cause of deeth? 1 Yes 2 No

25. Wes case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Menner of Deeth: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigetion 6 Could not be determined

28a. Date of injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(a) and manner stated.

29b. Signeture end title of certifier
29c. License number: D 00 153774
29d. Date signed (Month, Day, Year): 01/30/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): F. Solondeh MD 7525 Greenway Center Dr Greenbelt MD 20770

State Registrar

31. Dete filed (Month, Day, Year): FEB 06 2001
32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Sidney Leroy Pierce, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0579-005
jhm
FRANCIS
PUNTE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#1,23a,27 perMEOG 4/5/01 **Certificate of Death**

Reg. No: 2001 03156

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCIS Michael Punte Jr. ~~FRANCIS M. PUNTE, JR.~~

2. Date of Death Month Day Year: FEBRUARY 02, 2001

3. Time of Death: 15:14 PM

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL

4b. City, Town, or Location of Death: ESSEX

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-07-0680

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 18, 1919

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9028 Hines Rd.

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self employed

16b. Kind of Business/Industry: Carpentry

17. Father's Name (First, Middle, Last): Francis M. Punte

18. Mother's Name (First, Middle, Maiden Surname): Bertha Idella Duval

19a. Informant's Name/Relationship (Type, Print): Mrs. Mildred C. Punte/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9028 Hines Rd. Baltimore, Md. 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: Feb. 6, 01

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc 1050 York Rd. Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): CARDIAC ARRHYTHMIA DUE TO MYOCARDIAL FIBROSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Stephen L Radentz, M.D.

29c. License number: OCME

29d. Date signed (Month, Day, Year): FEBRUARY 03, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 03157

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elijah Price

2. Date of Death: Month February Day 02 Year 2001

3. Time of Death: 1 pm

4a. Facility Name (If not institution, give street and number): Mariner Health of Bel Air

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 189-03-9762

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 5, 1915

9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 825 Woodmont Court

10f. Zip Code: 21085

10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 Years

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber

16b. Kind of Business/Industry: Baltimore City

17. Father's Name (First, Middle, Last): David W. Price

18. Mother's Name (First, Middle, Maiden Surname): Florenda Simoson

19a. Informant's Neme/Relationship (Type, Print): Dorothy L. Price (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 825 Woodmont Ct. Joppa, Maryland 21085

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial Park

Date: 2/5/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Gregory E. Reed

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting In death): a. Alzheimers Dimentia — 5years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated. 2☐Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D34652

29d. Date signed (Month, Day, Year): February 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Haswell 2 North Avenue Bel Air Maryland 21014

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Price, Elijah

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03158

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dowling Jones Price

2. Date of Death (Month, Day, Year): FEBRUARY 2 2001

3. Time of Death: 5:40AM

4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-07-7345

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 6 1917

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 69 Oakway Rd.

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: '41-'46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — Specify:

14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Batallion Chief

16b. Kind of Business/Industry: Fire Dept./ Co. Government

17. Father's Name (First, Middle, Last): Arthur Gordon Price

18. Mother's Name (First, Middle, Maiden Surname): Mary Emmeline Jones

19a. Informant's Name/Relationship (Type, Print): Mrs. Yolan Virginia Price/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 69 Oakway Rd., Timonium, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Jessops United Meth. Ch. Cem. — Date: 2/5/01 — 20c. Location - City or Town, State: Sparks, MD

21. Signature of Funeral Service Licensee: Lowell M. Lemmon

22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

To Be Completed by Funeral Director

Price, Dowling

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic obstructive pulmonary disease — Not Available

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Sepsis due to coagulase negative staphylococci and candida

Atrial Fibrillation

Ileus - idiopathic

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard J. Gross M.D.

29c. License number: D18738

29d. Date signed (Month, Day, Year): February 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard J. Gross M.D., Suite 200, 4924 Campbell Blvd, Baltimore MD 21236

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03159

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FREDERICK J. PARKIN, JR
2. Date of Death: Month FEB Day 4 Year 2001
3. Time of Death: 2300
4a. Facility Name (If not institution, give street and number): GENESIS ELDERCARE @ HAMMONDS LANE
4b. City, Town, or Location of Death: BROOKLYN PARK
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217.26.3039
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 12, 1931
9. Birthplace (State or Foreign Country): PENN

Usual Residence of Decedent

10a. State: MD
10b. County: ANNE ARUNDEL
10c. City, Town or Location: LINTHICUM
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 568 SHIPLEY RD.
10f. Zip Code: 21090
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1955-65
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SERVICE MANAGER
16b. Kind of Business/Industry: CHESAPEAKE SUPPLY, EQUIP.

17. Father's Name (First, Middle, Last): FREDERICK J. PARKIN, SR.
18. Mother's Name (First, Middle, Maiden Surname): MARGUERITE ALEXANDER

19a. Informant's Name/Relationship (Type, Print): MARILYN O. PARKIN WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 568 SHIPLEY RD LINTHICUM MD. 21090

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARLINGTON NATIONAL CEM
Date: 2/15/01
20c. Location - City or Town, State: ARLINGTON, VA

21. Signature of Funeral Service Licensee: K GREGORY FINK MO1148
22. Name and Address of Facility: FINK FUNERAL HOME, P.A. 426 CRAIN HWY, S. GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARCINOMA OF PANCREAS — 18 MMLG

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Syed M. A. Rizvi
29c. License number: D40491
29d. Date signed (Month, Day, Year): Feb-06-2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Syed M. A. Rizvi 800 North Hammonds Ferry Rd Linthicum 21090

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Erik Warren Quisgard

2. Date of Death Month: February Day: 4 Year: 2001

3. Time of Death: 0316 A.M. / P.M. 1:45

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-40-1738

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11-12-1943

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: MD

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐Yes 2☒No

10a. Street and Number: 33 Seaford Avenue

10f. Zip Code: 21221

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Merried 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machine repairman

16b. Kind of Business/Industry: Middle River Aircraft Systems

17. Father's Neme *(First, Middle, Last)*: Rolf Quisgard

18. Mother's Name *(First, Middle, Maiden Surname)*: Zelda Graves

19a. Informant's Name/Relationship *(Type, Print)*: wife Dale Quisgard

19b. Maiting Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 33 Seaford Ave., Baltimore, Maryland 21221

20a. Method of Disposition: 1☒Buriel 2☐Cremation 3☐Removel from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Oaklawn

Date: 2/9/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Marea D. Zannino

22. Name and Address of Fecility: Joseph N. Zannino Jr. FH 263 S. Conkling st., Baltimore, Maryland 21224

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervet Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Atherosclerotic CAD

Due to (or as a consequence of):

Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Hypercholesterolemia

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☐No

26. Place of Death *(Check only one)*: Hospitel: 1☐Inpatient 2☑ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined

28a. Dete ol Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best ol my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ Michael Pipkin MD

29c. License number: D 196972

29d. Date signed *(Month, Day, Year)*: FEBRUARY, 5, 2001

30. Neme and address of person who completed cause ol death (Item 23a) (Type, Print): MICHAEL PIPKIN, MD 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 0 6 2001

32. Registrar's Signature: ▶ Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Quisgard Eric
Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03161

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carole J. Rawlings

2. Date of Death Month Day Year: February 1, 2001

3. Time of Death: 4:00PM

4a. Facility Name (If not institution, give street and number): 5785 Paradise Avenue

4b. City, Town, or Location of Death: Elkridge

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 185-26-3296

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/12/1933

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Elkridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5785 Paradise Avenue

10f. Zip Code: 21227

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Martin VaBlargan

18. Mother's Name (First, Middle, Maiden Surname): Clara Hassfenphlug

19a. Informant's Name/Relationship (Type, Print): Connie McCrory / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2814 Eastshire Drive, Baltimore, Maryland, 21230

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cramatory or other place): Ivy Hill Cemetary

Date: 02/03/01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Debbie M Davis

22. Name and Address of Facility: Fleck Funeral HOme 7601 Sandy SpringsRoad Laurel, Maryland, 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC SQUAMOUS CELL CARCINOMA OF RT. LUNG — 19 MONTHS

Due to (or as a consequence of):

b. HYPOKALEMIA — 2 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. HYPOMAGNESEMIA — "

Due to (or as a consequence of):

d. HYPOPHOSPHATEMIA — "

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

TYPE II DIABETES MELLITUS

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred: N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Soon Ja Kim, M.D.

29c. License number: D 22832

29d. Date signed (Month, Day, Year): 02/02/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SOON JA KIM, M.D. 5808 MAIN STREET, ELKRIDGE MD 21075

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 03162

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Dorothy M. Rock	February 3, 2001	7:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1401 Weldon Place South # C3	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-24-3443	1☐M 2☒F	73 Yrs.			Nov. 2, 1927	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1401 Weldon Place South #C3	21211	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry Thompson	Margaret Getz

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21211
Nathan Rock Husband	1401 Weldon Place South #C3 Baltimore, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Baltimore-Washington Crematory	02/05/01	Laurel, Maryland

21. Signature of Funeral Service License: Terry H. Carpenter

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIFOCAL LEUCOENCEPHALOPATHY — Approximate Interval Between Onset and Death: 2 months

Due to (or as a consequence of):

b. Acute Leukemia — 12 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of delivery (Month, Day, Year)
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetet death 3☐Ectopic pregnency 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Phyelcian:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐**Medical Examinar:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M.D.	D44944	February 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STANLEY WALKER M.D. 3333 North Calvert Street Baltimore MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 06 2001	Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03163

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Margaret Stewart

2. Date of Death (Month, Day, Year): February 2, 2001

3. Time of Death: 1:00 AM

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-28-6085

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 26, 1931

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Rosedale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9573 Shiewood Ct.

10f. Zip Code: 21237

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th. Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Factory Worker

16b. Kind of Business/Industry: Manufacturing

17. Father's Name *(First, Middle, Last)*: James Starr

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret E. Cummins

19a. Informant's Name/Relationship *(Type, Print)*: Douglas O. Stewart/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9573 Shiewood Ct. Baltimore MD 21237

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery

Date: 02/05/2001

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: [signature] #002521

22. Name and Address of Facility: Charles S. Zeiler & Son, Inc. 6224 Eastern Ave. Baltimore MD 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	RECURRENT FLESH PULMONARY EDEMA	3 DAYS
Due to (or as a consequence of): b.	ACUTE NON Q MYOCARDIAL INFARCTION	1 WEEK
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	CORONARY ARTERY DISEASE	
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: MULTIPLE CEREBRAL VASCULAR ACCIDENTS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D-38754

29d. Date signed *(Month, Day, Year)*: 02-02-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MALIKA WASEEM, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 0 6 2001

32. Registrar's Signature: [signature] Sparks

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Stewart Mary

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

MM10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03164

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN EDWARD SMITH

2. Date of Death (Month, Day, Year): February 01 2001

3. Time of Death: 9:05 am

4a. Facility Name *(If not institution, give street and number)*: JOSEPH RICHIE HOSPICE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 422-66-8866

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 53 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 13 1948

9. Birthplace *(State or Foreign Country)*: ALABAMA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: HARFORD CO

10c. City, Town or Location: ABERDEEN

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 404 Rogers Street

10f. Zip Code: 21001

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 yrs; College (1-4or 5+): 4+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: EDUCATION SPECIALIST

16b. Kind of Business/Industry: APG-FED GOVERNMENT

17. Father's Name *(First, Middle, Last)*: MAPLE SMITH

18. Mother's Name *(First, Middle, Maiden Surname)*: ANNA PEASANT

19a. Informant's Name/Relationship *(Type, Print)*: ABIGIAL H SMITH/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 404 Rogers St., Aberdeen, Md., 21001

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: ST JAMES CEMETERY

Date: 2-6-01

20c. Location - City or Town, State: HAVRE DE GRACE, MD

21. Signature of Funeral Service Licensee: Charles W. Powell

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 321 S. Philadelphia Blvd, Aberdeen Md 21001

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Squamous carcinoma of perineum	2 mo
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Hydradenitis suppurativa	10 yrs
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John K. Payne, MD

29c. License number: D 1302

29d. Date signed *(Month, Day, Year)*: Feb 1, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Payne 2565 N. Charles St 21204

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 0 6 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

John Smith 2/1/01 9:05am

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03165

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Christian Sauter
2. Date of Death (Month, Day, Year): February 4, 2001
3. Time of Death: 0524
4a. Facility Name *(If not institution, give street and number)*: Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-09-5965
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT 23, 1917
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1412 N. Rolling Road
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1941-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Plasterer
16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Gideon Sauter
18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Schroeder

19a. Informant's Name/Relationship *(Type, Print)*: Elaine Lewis/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1359 Dicus Mill Road Severn, MD 21144

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lakeview Memorial Park
Date: 2-7-01
20c. Location - City or Town, State: Eldersburg, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. *Approximate Interval Between Onset and Death*

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic Heart Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: C Webb, MD
29c. License number: D0055459
29d. Date signed *(Month, Day, Year)*: February 4, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C.B. Webb, M.D. Northwest Hospital Center Randallstown, MD 21133

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001
32. Registrar's Signature: [illegible] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03166

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jan Ball Sands

2. Date of Death Month Day Year: February 4, 2001

3. Time of Death: 12:23 AM

4a Facility Name *(If not institution, give street and number)*: 94 Carroll Drive

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 363-58-5807

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 1, 1953

9. Birthplace *(State or Foreign Country)*: Michigan

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 94 Carroll Drive

10f. Zip Code: 21403

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Program Manager

16b. Kind of Business/Industry: Naval Contracting

17. Father's Name *(First, Middle, Last)*: Harold Sands

18. Mother's Name *(First, Middle, Maiden Surname)*: Erma Yuhas

19a. Informant's Name/Relationship *(Type, Print)*: Laurel K. Sands/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 94 Carroll Drive Annapolis, MD 21403

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc.

Date: 2-6-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Adenocarcinoma unknown primary — 14 mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

26a. Date of Injury *(Month, Day Year)*

26b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: J. Selonick MD

29c. License number: 019838

29d. Date signed *(Month, Day, Year)*: 2/5/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart E. Selonick, MD 900 Bestgate Annapolis, Md.

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 0 6 2001

32. Registrar's Signature: Barbara P. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03167

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Joseph Seiler

2. Date of Death Month Day Year: February 3, 2001

3. Time of Death: 9:05 a M

4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center Towson

4b. City, Town, or Location of Death:

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-14-7668

6. Sex: 1 X M 2 F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APR 19, 1915

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 X Yes 2 No

10e. Street and Number: 1628 Roundhill Road

10f. Zip Code: 21218

10g. Citizen of What Country: USA

11. Marital Status: 1 Never Married 2 Married 3 X Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Able Bodied Seamen

18b. Kind of Business/Industry: Exxon

17. Father's Name (First, Middle, Last): Louis Seiler

18. Mother's Name (First, Middle, Meiden Surname): Matilda Rippurger

19a. Informant's Name/Relationship (Type, Print): Judith D. Woods/Step-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7005 Kenleigh Road Baltimore, MD 21212

20a. Method of Disposition: 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc. Date: 2-6-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. COPD — Approximate Interval: 40 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Data of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Wes cese referred to medical examiner? 1 Yes 2 X No

28. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death: 1 X Netural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Yeer): N/A

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and menner as stated. 2 **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D41104

29d. Date signed (Month, Day, Year): 2.3.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ted Hawk MD 7825 York Rd Towson MD 21204.

State Registrar

31. Date filed (Month, Day, Yeer): FEB 0 6 2001

32. Registrar's Signature: Geneva B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Seiler, John

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03168

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARthur, J, SORQUIST
2. Date of Death Month/Day/Year: 02 03 01
3. Time of Death: 21:02
4e. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 079-20-6370
6. Sex: 1 [X] M 2 [ ] F
7. Age (in yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 17, 1927
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Tracy's Landing
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6103 Franklin Gibson Road
10f. Zip Code: 20779-1236
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Longshoreman
16b. Kind of Business/Industry: Shipping

17. Father's Name (First, Middle, Last): Arthur John Sorquist
18. Mother's Name (First, Middle, Maiden Surname): Signe Malstrom

19e. Interment's Name/Relationship (Type, Print): Karen L. Krus/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6103 Franklin Gibson Road Tracy's Landing, MD 20779

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 2-6-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ David L. McDonald
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory arrest	1w.
Due to (or as a consequence of):	b. Congestive heart failure	1w.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. Coronary disease	4 years
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
- diabetes mellitus.
- peripheral vascular disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] M.D.
29c. License number: D31998.
29d. Date signed (Month, Day, Year): 02-04-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHELE SMASTA-GORDON. 205 Ridgely Ave Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit [illegible]

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03169

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STANLEY SANTOS

2. Date of Death (Month, Day, Year): FEBRUARY 1 2001

3. Time of Death: 12:45PM

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216 36 2971

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 2, 1939

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 735 DOLPHIN STREET

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S. OF A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): UNKNOWN

College (1-4or 5+): UNKNOWN

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): GANG LEADER

16b. Kind of Business/Industry: SANITATION

17. Father's Name (First, Middle, Last): STANLEY SANTOS, SR.

18. Mother's Name (First, Middle, Maiden Surname): SARAH GALLAWAY

19a. Informant's Name/Relationship (Type, Print): HATTIE SANTOS (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 735 DOLPHIN STREET BALTIMORE, MARYLAND 21217

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY

Date: 2/8/2001

20c. Location - City or Town, State: LANDSDOWN, MARYLAND

21. Signature of Funeral Service Licensee: LEWIS T. GWYNN — Lewis T. Gwynn

22. Name and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 21215-6393, 4517 PARK HEIGHTS AVENUE BALTIMORE, MD.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACQUIRED IMMUNODEFICIENCY SYNDROME — 2 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gregory Clark, M.D.

29c. License number: RES-000

29d. Date signed (Month, Day, Year): FEBRUARY 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gregory Clark Johns Hopkins Hospital 600 North Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03170

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ella M. Scoins

2. Date of Death (Month, Day, Year): February 5, 2001

3. Time of Death: 3:15 AM

4a. Facility Name (If not institution, give street and number): 2013 Governor Thomas Bladen Way #104

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 133-24-8701

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV 1, 1932

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2013 Governor Thomas Bladen Way #104

10f. Zip Code: 21401

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electronic Technician

16b. Kind of Business/Industry: Television Production

17. Father's Name (First, Middle, Last): Ralph E. Schlagenhauf

18. Mother's Name (First, Middle, Maiden Surname): Dorothy E. Thompson

19a. Informant's Name/Relationship (Type, Print): Sandra J. Sarkady/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1645 Homewood Road Annapolis, MD 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 2-6-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Adenoca of pancreas — 5 mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial and V ventricular ectopy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M M Mullins, MD

29c. License number: D26375

29d. Date signed (Month, Day, Year): 2/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. Mullins, M.D. 586 Bellerive Drive Suite 2B Annapolis, MD

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03171

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
John W. Shilling, Sr.	Feb. 3, 2001	4:23 PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Stella Maris Nursing Center	Timonium	Baltimore County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-07-8282	XX 1 M 2 F	81 Yrs.			April 29, 1919	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore Co.	Timonium	1 Yes XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
1 Hillbrook Court	21093	USA

11. Merital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1 Never Married 2 Married XX Widowed 4 Divorced	1 Yes XX No If Yes, Give Yeer or Dates:	1 Yes XX No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
unknown		Management	Construction Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Edgar Shilling	Effie Barnes

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Michael D. Shilling (Son)	11609 St. Davids Lane Lutherville, MD 21093

20a. Method of Disposition	20b. Plece of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX Burial 2 Cremation 3 Removal from Stete 4 Donation 5 Other (Specify)	Woodlawn Cemetery	2/6/2001	Woodlawn, Maryland

21. Signature of Funeral Service Licensee: Terry L. Capute

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. End stage dementia

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as e consequence of):

c. Due to (or as e consequence of):

d. Due to (or as e consequence of):

IF FEMALE: 23b. Wes decedent pregnent in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnency 1 Live birth 2 Fetel deeth 3 Ectopic pregnency 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined				

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Syed Haque MD.	D0546 36	2/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Syed Haque 201-109 Back River Neck Rd Balto. MD 21221

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 0 6 2001	Brenda D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03172

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret A. Schultz
2. Date of Death (Month, Day, Year): Feb. 1, 2001
3. Time of Death: 8:30 AM
4a. Facility Name *(If not institution, give street and number)*: Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 218-26-4550
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 6, 1930
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12409 Dover Road
10f. Zip Code: 21136
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: In Own Home

17. Father's Name *(First, Middle, Last)*: Austin E. Donovan
18. Mother's Name *(First, Middle, Maiden Surname)*: Ann Nolan

19a. Informant's Name/Relationship *(Type, Print)*: G. Joseph Schultz Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12409 Dover Road Reisterstown, MD 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lorraine Park Cem.
Date: 2/3/01
20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: Tracy H. Carpenter
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis	3 weeks
Due to (or as a consequence of): b.	Calciphylaxis	5 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	End Stage Renal Disease	1 year
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robert McWilliams MD
29c. License number: D 55741
29d. Date signed *(Month, Day, Year)*: February 1, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert McWilliams, Suite 3853, GBMC Hospital, 6701 N. Charles St, Baltimore, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03173

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JANET SHOATS

2. Date of Death: Month FEBRUARY Day 2, Year 2001

3. Time of Death: 7 05 PM

4a. Facility Name (If not institution, give street and number): STELLA MARIS @ MERCY HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 089-56-0195

6. Sex: 1☐ M 2☐ F

7. Age (In yrs. last birthday): 38 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2-6-1962

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MD.

10b. County: PLAINFIELD

10c. City, Town or Location: PLAINFIELD

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1022 ROSE ST. APT. B3

10f. Zip Code: 06070

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): -12-

College (1-4or 5+): -2-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DATA CLERK

16b. Kind of Business/Industry: COMPUTER

17. Father's Name (First, Middle, Last): JEROME P. ROBINSON, SR.

18. Mother's Name (First, Middle, Maiden Surname): EDITH SPILLERS

19a. Informant's Name/Relationship (Type, Print): EDITH CHARITY (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7818 BRUTON DR. GLEN BURNIE, MARYLAND 21060

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HILLSIDE CEMETERY

Date: 2-6-2001

20c. Location - City or Town, State: PLAINFIELD, NEW JERSEY

21. Signature of Funeral Service Licensee: Jaathe D. Hibner

22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Metastatic Adenocarcinoma - Unknown Primary

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): STELLA MARIS AT MERCY

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr. Thomas M

29c. License number: D40854

29d. Date signed (Month, Day, Year): FEBRUARY 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #17, 19A PER 17, 19A PER F.H. G792 1-6-02 WR

Certificate of Death

Reg. No 2001 03174

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
JULIUS		SILVERBERG	FEBRUARY 3, 2001	11:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
CHERRYWOOD NURSING HOME	REISTERSTOWN	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-07-1834	1 X M 2 ☐ F	79 Yrs.			AUG. 4, 1921	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	OWINGS MILLS	1 ☐ Yes 2 XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8008 VALLEY MANOR ROAD #2A	21117	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	1 XX Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
8		MUTUAL CLERK	MARYLAND MILE TRACKS

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
~~JACOB~~ JACOB SILVERBERG ~~SILBERBERG~~	ROSE PENNICK

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BETTY ~~SILBERBERG~~ SILVERBERG / WIFE	8008 VALLEY MANOR ROAD #2A - OWINGS MILLS, MD 21117

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	LIBERTY PARK SHAAREI ZION	2/5/01	RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: Scott M. Cuttler

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Bilateral pneumonia	1 month
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Dementia	
	Due to (or as a consequence of):	
	c. Parkinson's	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(R) frontal lobe meningioma

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No	1 ☐ Yes 2 X No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Alan Lefkowitz, M.D.	D37035	2-5-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 5400 OLD COURT RD Suite 205, Randallstown, MD 21133

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 0 6 2001	D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03175

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY TUCKER

2. Date of Death Month / Day / Year: January 29, 2001

3. Time of Death: 1230 P

4a. Facility Name *(If not institution, give street and number)*: LORRAINE FRANKFORD N.H.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-26-1554

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 1/12/12

9. Birthplace *(State or Foreign Country)*: N.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1305 N. KENWOOD AVENUE

10f. Zip Code: 21213

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 ST; College (1-4or 5+): N/A

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: HOUSE

17. Father's Name *(First, Middle, Last)*: TONY PAYNE

18. Mother's Name *(First, Middle, Maiden Surname)*: MARYELLA FREEDOM DALTON

19a. Informant's Name/Relationship *(Type, Print)*: HARRISON TUCKER / SPOUSE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1305 N. KENWOOD AVE - BALTO, MD. 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WOODLAWN CEMETERY

Date: 2/2/01

20c. Location - City or Town, State: WOODLAWN, MD.

21. Signature of Funeral Service Licensee: Jennifer Cromartie

22. Name and Address of Facility: BETTS FUNERAL HOME 1129 N. CAROLINE ST - BALTO., MD. 21213

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARRYTHYMIA (SUDDEN DEATH) — MINUTES

Due to (or as a consequence of):

b. ASCVD — YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. HTN — YRS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ADVANCED DEMENTIA, CVA & DYSPHAGIA, COPD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: 041291

29d. Date signed *(Month, Day, Year)*: 2/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JONATHAN GITTER 21 CROSSMOOR DR. OWINGS MILLS 21117

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM: 20B PER F.H. G792 WR; **Certificate of Death** Reg. No. 2001 03176

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Howard V. Toyer			1 / 31 / 2001	0200 AM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
2632 Harlem Avenue	Baltimore		NA	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-32-9006	1 X M 2 F	64 Yrs.			12-29-1936	Md

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	NA	Baltimore	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2632 Harlem Avenue	21216	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5th grade	NA	Baker	Bakery

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Howard King	Dorothy Toyer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothy Harrington-Mother	2632 Harlem Avenue Balto, md 21216

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	King Mem ARBUTUS MEM. PARK	2-7-01	Arbutus, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Dale March	Mark West F.H. 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SQUAMOUS CELL CARCINOMA of NeCK	3 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease	10 years
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D37928	February 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
2435 West Belvedere Avenue Baltimore MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 06 2001	G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To be Completed by Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03177

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DANA L. TREMBLAY
2. Date of Death Month Day Year: FEBRUARY 1, 2001
3. Time of Death: 0530
4a. Facility Name *(If not institution, give street and number)*: 124 MAIN AVE SE
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 027.20.3366
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: DEC 4, 1927
9. Birthplace *(State or Foreign Country)*: MASS

Usual Residence of Decedent

10a. State: MD
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 124 MAIN AVE SE
10f. Zip Code: 21061
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: KOREA
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ELECTRICIAN
16b. Kind of Business/Industry: LOCAL 24

17. Father's Name *(First, Middle, Last)*: GEORGE E. TREMBLAY
18. Mother's Name *(First, Middle, Maiden Surname)*: GLADYS G. PEIRCE

19a. Informant's Name/Relationship *(Type, Print)*: MARGARET M. TREMBLAY WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 124 MAIN AVE. SE GLEN BURNIE, MD 21061

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BAYVIEW CREMATORY
Date: 2FEB01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: K. GREGORY FINK MO1148
22. Name and Address of Facility: FINK FUNERAL HOME, P.A. 426 CRAIN HWY S GLEN BURNIE, MD 21061

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. AMYOTROPHIC LATERAL SCLEROSIS (ALS) — 4 YEARS

Due to (or as a consequence of):
b. RESPIRATORY INSUFFICIENCY — 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: CORSE - NEUROLOGIST
29c. License number: D42763
29d. Date signed *(Month, Day, Year)*: 2FERUARY01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREA M. CORSE, M.D. JOHNS HOPKINS HOSPITAL, MOYER 5-119, 600 N. WOLFE ST, BALTIMORE, MD.

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM # 25 per M.E. G792 020601 SS

Certificate of Death

Reg. No. 2001 03178

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Ernest	E.	Tarter	1	24	2001	6:06a. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2804 Chelsea Terrace	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-52-0743	1 [X] M 2 [ ] F	43 Yrs.			6-28-1957	Md

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	N/A	Baltimore	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2804 Chelsea Terrace	21216	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	3 years	Housing Inspector	Baltimore City Housing Authority

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Bernard C. Tarter	Cecilia

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Tracy L. Tarter - Wife	2804 Chelsea Terrace Baltimore, Md 21216

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	New Cathedral CEMET	1/29/2001	Baltimore, Md

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: March F/H West 4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Mucous Plugging in Association with Bronchitis	1 hour or less
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Non-traumatic quadriplegia	22 months
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robert B Shochet MD	D36356	1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert B. Shochet MD 2435 W. Belvedere Avenue Suite 22 Baltimore Maryland 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 0 6 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03179

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Freda E. Totaro

2. Date of Death: Month: Feb; Day: 2; Year: 2001

3. Time of Death: 5:55 pm

4a. Facility Name (If not institution, give street and number): MARINER Health - Bel AIR

4b. City, Town, or Location of Death: Bel AIR

4c. County of Death: HARford

Funeral Director

5. Social Security Number: 212-16-3224

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr 15, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1457 Harford Sq. Drive

10f. Zip Code: 21040

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George W. Amey

18. Mother's Name (First, Middle, Maiden Surname): Johanna E. Frank

19a. Informant's Name/Relationship (Type, Print): Barbara Melber /Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1457 Harford Sq.Drive, Edgewood, MD 21040

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Chesapeake Crematory

Date: Feb 5 2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ [signature] M00986

22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Renal Failure — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Nephrosclerosis — Due to (or as a consequence of): — } over a year

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Severe Dementia

Cerebrovascular Insufficiency

Suspected Adrenal Tumor

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, snd due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D19583

29d. Date signed (Month, Day, Year): February 2, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): MANUEL M. LAZATIN MD 8 Law Street Aberdeen, Maryland 21001

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signature: ▶ [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Totaro Freda

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03180

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Charles T. Turner Jr.	February 2 2001	8:00 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
347 Grove Park Road	Baltimore	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217 09 7841	1☒M 2☐F	82 Yrs.			Feb. 8, 1918	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
347 Grove Park Road	21225	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th		Highway Inspector	City of Baltimore

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles T. Turner Sr.	Genevieve Fisher

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ida Turner / Wife	347 Grove Park Road Baltimore, Maryland 21225

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Glen Haven Mem. Park	Feb. 5,2001	Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Anna M Gramuglia

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Metastasis

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mario J. Reda M.D.

29c. License number: D09732

29d. Date signed (Month, Day, Year): 2/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO J. REDA MD 4211 Fleet St. Balto MD. 21225

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03181

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): LOUIS TAKOVICH SR.

2. Date of Death — Month: JANUARY Day: 29 Year: 2001

3. Time of Death: 8:59 PM

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

5. Social Security Number: 232 09 6317

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 17, 1913

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 112 - 8th Avenue

10f. Zip Coda: 21225

10g. Citizan of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No — If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada complatad): Elementary/Secondary (0-12): 6th — Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired): Welder

16b. Kind of Businass/Industry: Local 193 Boiler Makers Inter.

17. Fathar's Nama (First, Middla, Last): Jacob Takovich

18. Mothar's Neme (First, Middle, Maidan Surnama): Frances Kovacic

19a. Informant's Neme/Raiationship (Type, Print): Angela Takovich / Wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 112 - 8th Avenue Baltimore, Maryland 21225

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or other place): Glen Haven Memorial Park

Data: 2/2/01

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signatura of Funaral Service Licensee: Jerome Framicourt

22. Nama and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disaasa or complications that causad tha daath. Do not antar the moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona ceuse on each line.

Approximata Intarval Batween Onsat and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. SEPSIS AND — 1 DAY

Dua to (or as a consequence of):

b. DISSEMINATED INTRAVASCULAR COAGULOPATHY

Sequantially list conditions, if any, leading to immediata ceuse. Enter Underlying Causa (Diseasa or injury that initiated evants resulting in death) Last

Dua to (or as a consequance of):

c. INTRA-ABDOMINAL INFECTION

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa given in Part I.

GASTROINTESTINAL BLEEDING

RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy parformed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to compilation of cause of death? 1 [ ] Yas 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Death (Check only ona) — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Other (Specify)

27. Manner of Daath: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Yaar)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28e. Piece of Injury - At home, farm, streat, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifiar (Check only one) 1 [X] **Certifying Phyaician:** To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: INTERNAL MEDICINE / SAMEER BADE

29c. License number: P13140

29d. Data signed (Month, Day, Year): JANUARY 29 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): SAMEER BADE MD, 3001 S HANOVER ST, BALTIMORE MD 21225

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

6

State Registrar

31. Data filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#25 perPHYG792 2/6/2001 EW

Certificate of Death

Reg. No. 2001 03182

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LISETTE THOMPSON

2. Date of Death: Month January Day 20, Year 2001

3. Time of Death: 5:30 pm

4a. Facility Name (If not institution, give street and number): Eltern Haus

4b. City, Town, or Location of Death: Dayton

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 219-36-9009

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 98 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 3, 1902

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1☐ Yes 2☐ No XX

10e. Street and Number: 835 Day Road

10f. Zip Code: 21784

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Reca - American Indien, Bieck, White, etc. Specify: white

15. Decedent's Education (Specify only highast grada completed): Elementery/Secondery (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Registrar

16b. Kind of Business/Industry: Univ. of Maryland

17. Fathar's Nama (First, Middla, Last): Henry Follmer

18. Mother's Neme (First, Middle, Meiden Surneme): Margaretha Hanitsch

19a. Informent's Neme/Reletionship (Type, Print): Jonathan Follmer, Sr./ Nephew

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 835 Day Road, Sykesville, MD 21784

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Loudon Park Cemetery

Date: 1/23/01

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funerel Service Licensee: Lori Holland

22. Name end Address of Fecility: Loudon Park Funeral Home, 3620 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in death)

a. Arteriosclerosis — Due fo (or es e consequence of): — yeers

b. Dementia — Due to (or es a consequence of): — yeers

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of exeminetion and/or investigetion, In my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: H.A. Oken MD

29c. Licanse number: D31172

29d. Dete signed (Month, Day, Year): Jan 23, 2001

30. Name and address of person who completed cause of daeth (Item 23a) (Type, Print): H.A. OKEN 3460 Ellicott Center Dr 103 Ellicott City MD

State Registrar

31. Dafa filed (Month, Dey, Year): FEB 06 2001

32. Registrer's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03183

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WAYNE TORSELL

2. Date of Death: Month JANUARY Day 31 Year 2001

3. Time of Death: 1320

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-44-8655

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 03, 1944

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Woodlawn

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6992 Rockfield Road

10f. Zip Code: 21244

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 12th; College (1-4or 5+): 2

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Insurance Manager

16b. Kind of Business/Industry: American General

17. Father's Neme (First, Middle, Last): Charles Torsell

18. Mother's Name (First, Middle, Maiden Surneme): Louise Butler

19a. Informent's Name/Reletionship (Type, Print): Margo E. Torsell-Wife

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 6992 Rockfield Rd. Baltimore MD 21244

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Garrison Forest Cem.

Date: 02/06

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name end Address of Feciliity: Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert-ielure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Finel disease or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Due to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpetient 2☑ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner**: On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, date and piece, and due to the ceuse(a) and menner steted.

29b. Signature and title of certifier: ▶ [signature] E. P. Williamson II MD

29c. License number: D11171

29d. Dete signed (Month, Dey, Year): JANUARY 31, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): E. P. WILLIAMSON II 405 FREDERICK ROAD CATONSVILLE 21228 MARYLAND

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrer's Signeture: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03184

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edna H. Taylor

2. Date of Death Month Day Year: 02 - 01 - 2001

3. Time of Death: 11:15 PM

4a. Facility Name *(If not institution, give street and number)*: Wesley Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 212-16-2427

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 09/30/1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 23 Briarwood Road

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own home

17. Father's Name *(First, Middle, Last)*: Robert Hall

18. Mother's Name *(First, Middle, Maiden Surname)*: Carrie Fisher

19a. Informant's Name/Relationship *(Type, Print)*: Berkeley Taylor

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10190 Cabery Road, Ellicott City, MD., 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lorraine Cemetery

Date: 02/03/2001

20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: ▶ Wanda L Lemmon M000741

22. Name and Address of Facility: Witzke Funeral Home 1630 Edmondson Avenue, Catonsville, MD., 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARRYTHMIA — ACUTE

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. HYPERTENSIVE CARDIOVASCULAR DISEASE — YEARS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA; CEREBROVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert E. Roby M.D.

29c. License number: D-19425

29d. Date signed *(Month, Day, Year)*: 2/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT E. ROBY M.D. 2211 W. ROGERS AVE. BALTO, MD 21209

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 06 2001

32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Taylor, Edna Hall

25

Y/F

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03185

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Daniels Taylor

2. Date of Death (Month, Day, Year): February 1, 2001

3. Time of Death: 7:25 PM

4a. Facility Name *(If not institution, give street and number)*: 1201 Hollins Lane

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 181-12-1205

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 13, 1917

9. Birthplace *(State or Foreign Country)*: Indiana

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1201 Hollins Lane

10f. Zip Code: 21209

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Professor

16b. Kind of Business/Industry: Towson State University

17. Father's Name *(First, Middle, Last)*: Jesse Daniels

18. Mother's Name *(First, Middle, Maiden Sumame)*: Elizabeth Henry

19a. Informant's Name/Relationship *(Type, Print)*: Carl E. Taylor/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1201 Hollins Lane Baltimore, MD 21209

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Metro Crematory, Inc.

Date: 2-2-01

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular fibrillation — minutes

Due to (or es e consequence of):

b. atherosclerosis — 20 yrs

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting In death) Last

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting In the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, tarm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Cartifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: M M Newman, M.D.

29c. License number: D27904

29d. Date signed *(Month, Day, Year)*: February 2, 2001

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): MARY M. NEWMAN, M.D. 10755 FALLS RD #200 LUTHERVILLE MD 21093

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 06 2001

32. Registrer's Signature: Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires thet the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03186

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Frederick Tolzman, Sr.

2. Date of Death (Month, Day, Year): JAN 31 2001

3. Time of Death: 5 22 AM

4a. Facility Name (If not institution, give street and number): Augsburg Lutheran Home

4b. City, Town, or Location of Death: Woodlawn

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-05-4875

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 98 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 30 1902

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Woodlawn

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6811 Campfield Rd.

10f. Zip Code: 21207-4698

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12

College (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator

16b. Kind of Business/Industry: Rendering

17. Father's Name (First, Middle, Last): Edward Henry Tolzman

18. Mother's Name (First, Middle, Meiden Surname): Sophie Spraener

19a. Informant's Name/Relationship (Type, Print): Edward F. Tolzman, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1713 Thornton Ridge Rd., Towson, MD 21204

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Lorraine Park Mausoleum

Date: 2/3/01

20c. Location - City or Town, State: Woodlawn, MD

21. Signature of Funeral Service Licensee: Lowell M. Lemmon

22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebral Thrombosis

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner aa stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D15872

29d. Date signed (Month, Day, Year): Jan 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harold Bell 25 Main St. Reisterstown 21136

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Edward J Tolzman
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23a perPHYG792 2/6/2001 EW

Certificate of Death

Reg. No. 2001 03187

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NELLIE VIGNA

2. Date of Death (Month, Day, Year): January 27, 2001

3. Time of Death: 13:35

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: - N/A

Funeral Director

5. Social Security Number: 215-07-3729

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 15, 1918

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 103 Center Place Apt 231

10f. Zip Code: 21222

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10 yrs

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier

16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): Harry Weitzel

18. Mother's Name (First, Middle, Maiden Surname): Cecelia Kraemer

19a. Informent's Name/Relationship (Type, Print): Michelle Karle Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 39 Rader Ct. Parkville, Md.21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory

Date: Jan 29 2001

20c. Location - City or Town, State: Baltimore City

21. Signature of Funeral Service Licensee: ▶ Anthony C Connelly

22. Name and Address of Facility: Connelly Funeral Home of Dundalk,P.A. 7110 Sollers Point Rd. Dundalk,Md.21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Right Ventricular Heart Failure — months

Due to (or as a consequence of):

TRICUSPID REGURGITATION — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast mass on the right.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: 21010

29d. Date signed (Month, Day, Year): January 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Evelyn Mentari, M.D. 4940 Eastern Avenue Baltimore Maryland 21224

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signature: ▶ Geneva B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03188

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marjorie Van landingham
2. Date of Death Month Day Year: Feb. 5, 2001
3. Time of Death: 5:38am
4a. Facility Name (If not institution, give street and number): 1100 New Hope Circle
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-44-0276
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July28,1945
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1100 New Hope Circle
10f. Zip Code: 21202
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: AfroAmerican

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Worker
16b. Kind of Business/Industry: Maryland Cup Co.

17. Father's Name (First, Middle, Last): William M. Vanlandingham
18. Mother's Name (First, Middle, Maiden Surname): Florine Johnson

19a. Informant's Name/Relationship (Type, Print): Marjorie Williams/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4320 Sheldon Ave. Balto. MD 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cem.
Date: Feb. 10, 2001
20c. Location - City or Town, State: Balto.,MD

21. Signature of Funeral Service Licensee: Calvin B. Scruggs
22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO. MD 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Coronary Artery Disease
Due to (or as a consequence of):
c. Diabetes Mellitus
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ledwin L. Cueto
29c. License number: D28541
29d. Date signed (Month, Day, Year): 2/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 700 Washington Blvd. Baltimore, MD- 21230

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03189

AMENDED ITEMS #4a, & 20b per fh G792 020601 SS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month / Day / Year	3. Time of Death
Margaret	Maxine	Weaver	Feb. 01 2001	9:00am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Augsburg ~~Lutheran~~ Lutheran Nursing Home	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
236-28-0557	1☐ M 2☒ F	82 Yrs.			11 18 18	O.H.

Usual Residence of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Pikesville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
7501 Shelowood Road	21208	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxican, Puerto Rican, atc.)	14. Race - American Indian, Black, White, atc.
1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grada completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired)	16b. Kind of Businass/Industry
Elementery/Secondery (0-12)	Collega (1-4or 5+)		
12th grade	5yrs +	School Teacher	Balto City Schools

17. Fathar's Name (First, Middle, Last)	18. Mothar's Name (First, Middle, Maiden Surnama)
Leonard Mayle	Mae Dalton

19a. Informant's Neme/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)
Sherly Grimes-Daughter	7501 Shelowood Road, Pikesville Md 21208

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cematary, cramatory or othar place)	Data	20c. Location - City or Town, Stete
☒ Buriel 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	Druid Ridge Cemetery	2/7/01	Pikesville ~~Pikewville,~~ Md

21. Signature of Funeral Service Licensee: Dala March

22. Name and Address of Facility: Baltimore, Maryland 21215
WM.C. March FH 4300 Wabash Avenue

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one ceuse on aach lina.

		Approximate Interval Between Onset and Death
Immediata Causa (Final disaasa or condition resulting in deeth)	a. brain Cance	1 year
Dua to (or es a consaquenca of):		
Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseesa or Injury that initiated events rasulting in death) Last	b.	
Due to (or es e consequenca of):		
	c.	
Due to (or as a consequanca of):		
	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

renal insufficiency

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1☐ Yaa 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yas 2☒ No	1☐ Yas 2☐ No

25. Was casa rafarred to medical examinar?	26. Place of Death (Check only ona)	
1☐ Yas 2☒ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Rasidanca 6☐ Othar (Specify)

27. Mannar of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one)
1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at tha time, deta and placa, and dua to the cause(s) and mannar statad.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D37573	Feb 2, 2001

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print)
25 Main St. Reisterstown MD 21136 Jef Tibell MD

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
FEB 0 6 2001	Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03190

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Madeline Virginia Woynovitz
2. Date of Death (Month, Day, Year): Feb. 2, 2001
3. Time of Death: 6:00 Am
4a. Facility Name (If not institution, give street and number): 5534 Council Street
4b. City, Town, or Location of Death: Arbutus
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-18-4341
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 11, 1914
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Arbutus
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5534 Council Street
10f. Zip Code: 21227
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Miles Brannen
18. Mother's Name (First, Middle, Maiden Surname): Clydia Poole

19a. Informant's Name/Relationship (Type, Print): JoAnn Bokman, daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5534 Council Street Arbutus, MD. 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park | Date: 1-5-01
20c. Location - City or Town, State: Elkridge, MD

21. Signature of Funeral Service Licensee: Rebecca Robinson
22. Name and Address of Facility: Ambrose Funeral Home, 1328 Sulphur Spring Rd. Arbutus, MD. 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. ISCHEMIC CARDIOMYOPATHY,
Due to (or as a consequence of):
b. ATRIAL FIBRILLATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anil Kumar Fatterpaker
29c. License number: D18319
29d. Date signed (Month, Day, Year): 02/02/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANIL KUMAR FATTERPAKER, 720-D, MAIDEN CHOICE LANE CATONSVILLE MD 21228

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Barbara B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03191

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Doris Mary Winkler

2. Date of Death: Month January Day 31 Year 2001

3. Time of Death: 7:00 P.M.

4a. Facility Name (If not institution, give street and number): 100 Ralph Road

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215 28 5228

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 8, 1932

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 100 Ralph Road

10f. Zip Code: 21060

10g. Citizen of What Country? U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Joseph Chester

18. Mother's Name (First, Middle, Maiden Surname): Henrietta Bell

19a. Informant's Name/Relationship (Type, Print): Charles Winkler / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1269 Maple Avenue Baltimore, Maryland 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 2/3/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna Bramiowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Endstage COPD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Rheumatoid Arthritis, A F.b, Debilitated, Malnourished, Anemia

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hospitalist

29c. License number: H0052024

29d. Date signed (Month, Day, Year): 2/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James A. Welker, DO SM627; Harbor Hosp Ctr. 3001 S. Hanover St.

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#26 perPHYG792 2/6/2001 EW

Certificate of Death

Reg. No. 2001 03192

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERNARD WALIGURSKI

2. Date of Death: Month JANUARY Day 24 Year 2001

3. Time of Death: 8:14 PM

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 216-01-2482

6. Sex: 1☑ M 2☐ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07/06/1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 919 N. Streeper Street

10f. Zip Code: 21205

10g. Citizen of What Country?: United States

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Traffic/Transportation

17. Father's Name (First, Middle, Last): Stephen Waligurski

18. Mother's Name (First, Middle, Maiden Surname): Petronella Kropp

19a. Informant's Name/Relationship (Type, Print): Stanley Kolb/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 919 N. Streeper Street Baltimore, Maryland 21205

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory

Date: 01/30

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.

22. Name and Address of Facility: David J. Weber Funeral Homes P.A. 401 S. Chester Street, Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. MYOCARDIAL INFARCTION — 15 minutes

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE — 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

HYPERCHOLESTEROLEMIA

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David A. Rapko MD

29c. License number: 20313

29d. Date signed (Month, Day, Year): JANUARY 24 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RAPKO, MD JOHNS HOPKINS BAYVIEW 4940 EASTERN AVE, BALTIMORE, MD 21224

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03193

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jon H. Williams

2. Date of Death: Month Feb. Day 04, Year 2001

3. Time of Death: 3:03 P.M

4a. Facility Name (If not institution, give street and number): 7169 Fairbrook Road

4b. City, Town, or Location of Death: Woodlawn

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-48-1018

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): 12-29-1946

9. Birthplace (State or Foreign Country): UNKNOWN

Usual Residence of Decedant

10a. State: MD.

10b. County: Baltimore

10c. City, Town or Location: Woodlawn

10d. Inside City Limits: 1 ☐ Yes 2 X No

10a. Street and Number: 7169 Fairbrook Road

10f. Zip Code: 21244

10g. Citizen of What Country? USA

11. Maritel Stetus: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yas 2 X No. If Yes, Give Yaer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yes 2 X No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grada completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Operator

16b. Kind of Business/Industry: U.S. Government

17. Father's Nema (First, Middla, Last): Howard J. Williams

18. Mother's Neme (First, Middle, Meiden Surname): Margaret Mason

19a. Intormant's Name/Reletionship (Type, Print): Doris Ann Williams-wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 7169 Fairbrook Road, Woodlawn, MD., 21244

20a. Mathod of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Othar (Specify)

20b. Piece ot Disposition (Neme of cemetery, crematory or othar placa): Crestlawn Cemetery

Date: 02-07-2001

20c. Location - City or Town, Stata: Marriotsville, MD.

21. Signature of Funerel Service Licensee: Bernard Dalsheimer

22. Neme end Address ot Fecility: Witzke Funeral Home, Inc. 1630 Edmondson Ave. Catonsville, Maryland 21228

Physician /Medical Examiner

23a. Part1. Entar the disease, or complicetions thet ceused the daeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart teilure. List only ona causa on aach lina.

Approximeta Intarval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in daeth)

a. Myocardial Infarction

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immedieta cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. atherosclerotic heart disease — years

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. atrial fibrillation, mitral valve regurgitation

23b. Did tobacco use contributa to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yas 2 X No

24b. Ware autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Piece ot Death (Check only ona): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 X Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 X Neturet 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be datarmined

28a. Dete ot Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place ot Injury - At home, tarm, street, factory, office building, atc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated. 2 ☐ Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the tima, date and place, and dua to the cause(s) and menner steted.

29b. Signature and title of certifier: Allen M Friedman MD

29c. License number: D24888

29d. Date signed (Month, Day, Year): February 5 2001

30. Name and address of person who completed causa ot death (Item 23a) (Type, Print): Allen M Friedman MD 222 W. Coldspring Lane Baltimore MD 21210

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001

32. Registrer's Signature: per D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-t show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03194

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RICHARD L. WRIGHT
2. Date of Death (Month, Day, Year): February 4 2001
3. Time of Death: 09:30 AM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-34-9435
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/11/33
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 14 S. WASHINGTON STREET
10f. Zip Code: 21231
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER
16b. Kind of Business/Industry: TRUCKING

17. Father's Name (First, Middle, Last): unknown WRIGHT
18. Mother's Name (First, Middle, Maiden Sumeme): unknown

19a. Informant's Name/Relationship (Type, Print): COLLEEN DANOWSKI / FRIEND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14 S. WASHINGTON ST. BALTIMORE, MD

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MOUNT CEME. Date: 2/6/01
20c. Location - City or Town, State: BALTO., MD

21. Signature of Funeral Service Licensee: ▶ Eugene J. Carter Jr
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTO., MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Renal Failure	days
Due to (or as a consequence of): b.	Severe dehydration	weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Respiratory failure	weeks
Due to (or as a consequence of): d.	Pulmonary embolism	days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe Pulmonary Hypertension, Atrial Fibrillation, Cardiomyopathy, Colon cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ , MD
29c. License number: RES-00
29d. Date signed (Month, Day, Year): FEB 04 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): OLADIPO ADENIYI JOHNS HOPKINS HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: by

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03195

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ann S. Young
2. Date of Death (Month, Day, Year): February 1, 2001
3. Time of Death: 9:25 am
4a. Facility Name (If not institution, give street and number): Hill Haven Nursing Center
4b. City, Town, or Location of Death: Adelphi, MD
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 216-60-3470
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 30, 1915
9. Birthplace (State or Foreign Country): MS

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Adelphi Maryland
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3210 Powder Mill Road
10f. Zip Code: 20783
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Draydon S. Todd
18. Mother's Name (First, Middle, Maiden Surname): Carlie Ford

19a. Informant's Name/Relationship (Type, Print): James K. Young / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4001 Metzerott Road College Park Maryland 20740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crametory or other place): Ashbury Cemetery,
Date: February 4, 2001
20c. Location - City or Town, State: Tremont, MS

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore, Maryland 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT — FOUR WEEKS

Due to (or as a consequence of):
b. CEREBRAL ATHEROSCLEROSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CARDIAC ARRYTHMIA.
DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: 22910
29d. Date signed (Month, Day, Year): FEB. 1ST 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ASIF S. QADRI, 4700 BERWYN HOUSE RD, COLLEGE PARK MD 20740

State Registrar

31. Date filed (Month, Day, Year): FEB 0 6 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03196

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANDREW JACKSON YOUNG, III

2. Date of Death (Month, Day, Year): FEBRUARY 2, 2001

3. Time of Death: 11:00AM

4a. Facility Name *(If not institution, give street and number)*: 304 BRIGHTWOOD CLUB DRIVE

4b. City, Town, or Location of Death: LUTHERVILLE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-14-0282

6. Sex: XX M 2☐ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 10-18-1916

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: BALTIMORE

10c. City, Town or Location: LUTHERVILLE

10d. Inside City Limits: 1☐ Yes XX No

10e. Street and Number: 304 BRIGHTWOOD CLUB DRIVE

10f. Zip Code: 21093

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married XX Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No If Yes, Give Year or Dates: 1940-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4 YEARS

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: EXECUTIVE

16b. Kind of Business/Industry: BARTON-COTTON CO.

17. Father's Name *(First, Middle, Last)*: ANDREW J. YOUNG, JR

18. Mother's Name *(First, Middle, Maiden Surname)*: ELIZABETH VAN SWEARINGDEN RHODES

19a. Informant's Name/Relationship *(Type, Print)*: CARLYLE BARTON,JR.(ATTORNEY)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 111 S.CALVERT ST.,BALTIMORE,MD.,21202

20a. Method of Disposition: 1☐ Burial XX Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GREEN MOUNT CREMATORY

Date: 2-5

20c. Location - City or Town, State: BALTIMORE,MD.,21202

21. Signature of Funeral Service Licensee: ▶ R. H. Butts

22. Name and Address of Facility: HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD,BALTIMORE,MARYLAND,21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or raspiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in deeth)

a. PROSTATE CANCER — 5YRS

Due to (or es e consequence of):

b. RENAL FAILURE — 1YR

Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Dua to (or as a consequenca of):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yaa 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes XX No

24b. Ware autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes XX No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home XX Residence 6☐ Other *(Specify)*

27. Menner of Death: XX Netural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: XX **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Paul Sapir

29c. License number: P10670

29d. Date signed *(Month, Day, Year)*: FEBRUARY 5,2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): DANIEL G. SAPIR,M.D.,10755 FALLS ROAD, LUTHERVILLE,MARYLAND, 21093

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 0 6 2001

32. Registrar's Signatura: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03197

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Florence J. Zerner			February 4, 2001	1:30 pm M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death		
2908 Gibbons Avenue	Baltimore	N/A		

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-16-7256	1☐ M 2☒ F	83 Yrs.			August 4, 1917	New Jersey

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2908 Gibbons Ave.	21214	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Parker	Mary Finley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
J. David Zerner-son	2908 Gibbons Ave., Baltimore, MD 21214

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Gardens of Faith Cemetery	2/7/01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ William G. Dau	Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic coronary artery disease

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐ Yes 2☐ No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Marvin Kawalewski MD	D21022	2-5-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. KAWALEWSKI MD 7672 BELAIR Rd. BALTO. MD 21236

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 06 2001	▶ B. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03198

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES ZALEWSKI
2. Date of Death — Month: JANUARY Day: 29 Year: 2001
3. Time of Death: 9:44AM
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 217-07-4348
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 10, 1917
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6849 Belclare Rd.
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 yrs. — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Millrite
16b. Kind of Business/Industry: General Motors
17. Father's Name (First, Middle, Last): Vincent Zalewski
18. Mother's Name (First, Middle, Maiden Surname): Stella Orlowsky
19a. Informant's Name/Relationship (Type, Print): Howard Zalewski son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6849 Belclare Rd. Dundalk, Md. 21222
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory — Date: Feb 1, 2001
20c. Location - City or Town, State: Baltimore City
21. Signature of Funeral Service Licensee: Anthony Connelly
22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, MD. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SEPSIS	ONE DAY
Due to (or as a consequence of): b.	PNEUMONIA	FIVE DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	EMPHYSEMA	FIFTEEN YEARS
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: FECAL IMPACTION, DECONDITIONING, CHRONIC RENAL INSUFFICIENCY, CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anthony C. Tamburello, III, MD
29c. License number: RES-600
29d. Date signed (Month, Day, Year): FEBRUARY 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANTHONY C. TAMBURELLO III MD 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

State Registrar

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #1 PER PHY G792 2-28-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03199

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rothwell Agnes — AGNES ROTHWELL
2. Date of Death: Month 1 / Day 19 / Year 01
3. Time of Death: 0930
4a. Facility Name (If not institution, give street and number): 1 Pence Drive Elkton, MD.
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 222-12-6429
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 6, 1910
9. Birthplace (State or Foreign Country): Cambridge, MD

Usual Residence of Decedent

10a. State: DE
10b. County: NewCastle
10c. City, Town or Location: Wilmington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 500 N. Walnut St.
10f. Zip Code: 19801
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): private families
16b. Kind of Business/Industry: domestic

17. Father's Name (First, Middle, Last): William J. Lee
18. Mother's Name (First, Middle, Maiden Surname): Mary J. (Cornish) Lee

19a. Informant's Name/Relationship (Type, Print): Donald Corregys
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 825 Morrison Ave. Bronx, New York 10473

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rolling Green Memorial Park
Date: 1/23/01
20c. Location - City or Town, State: West Chester, PA

21. Signature of Funeral Service Licensee: Robert W. Wright
22. Name and Address of Facility: The House of Wright Mortuary P.O.Box 447 Wilm., DE 19899

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardio pulmonary failure

Due to (or as a consequence of):
b. Cerebral vascular accident

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Breast Cancer, Dementia.

Due to (or as a consequence of):
d. Dysphagia.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Madhu Schdev.
29c. License number: D0026183
29d. Date signed (Month, Day, Year): January 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Madhu Schdev 322 E. Cecil Ave. Northeast, MD 21901

State Registrar

31. Date filed (Month, Day, Year): JAN 2 8 2001
32. Registrar's Signature: B. Sparks

1/23/2001

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 03200

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH BENEDICT BOWLES, JR.

2. Data of Death — Month: JANUARY Day: 23, Year: 2001

3. Time of Death: 10:30 AM

4a. Facility Name (If not institution, give street and number): 40445 BEACH DRIVE

4b. City, Town, or Location of Death: MECHANICSVILLE

4c. County of Death: ST. MARY'S

Funeral Director

5. Social Security Number: 579-36-0172

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 16, 1929

9. Birthplace (State or Foreign Country): WASHINGTON, D.C.

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ST. MARY'S

10c. City, Town or Location: MECHANICSVILLE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 40445 BEACH DRIVE

10f. Zip Code: 20659

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EXECUTIVE PROTECTIVE SERVICE OFFICER

16b. Kind of Business/Industry: U.S. FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last): JOSEPH BENEDICT BOWLES

18. Mother's Name (First, Middle, Maiden Surname): KATHRYN R. SPRINGER

19a. Informant's Name/Relationship (Type, Print): CHRISTINE M. NICHOLSON/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3111 KNOLEWATER COURT, WALDORF, MARYLAND 20602

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): RESURRECTION CEMETERY — Data: 1/27/2001

20c. Location - City or Town, State: CLINTON, MARYLAND

21. Signature of Funeral Service Licensee: JOHN P. KNISLEY M01164

22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156

JPK

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or haart failura. List only one cause on each line.

Approximata Interval Batwaen Onset and Death

Immediata Causa (Final diseasa or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Dilated Cardiomyopathy

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Atherosclerotic Heart Disease

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I.

Type 2 Diabetes Mellitus

Malignant Pleural Effusion

23b. Did tobacco usa contributa to the cause of death? 1 [ ] Yaa 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of daath? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical examinar? 1 [ ] Yas 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Henry Burke MD

29c. License number: D01009

29d. Data signed (Month, Day, Year): 1-24-01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): HENRY L. BURKE, MD, 115A LA GRANGE AVE., LA PLATA, MD 20646

State Registrar

31. Dete filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03201

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hazel Margaret Bramble

2. Date of Death (Month, Day, Year): January 22 2001

3. Time of Death: 4:50 pm

4a. Facility Name (If not institution, give street and number): Mallard Bay Care Center

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 217-10-8567

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 31, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 701 Race St. #103

10f. Zip Code: 21613

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): nurses aide

16b. Kind of Business/Industry: general hospital

17. Father's Name (First, Middle, Last): Walter Harrison Burton

18. Mother's Name (First, Middle, Maiden Surname): Etta Fitzhugh

19a. Informant's Name/Relationship (Type, Print): Sandra Meredith - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3018 Steamer Run Rd., Cambridge, MD 21613

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Dorchester Memorial Park

Date: 1-25

20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: ▶ Kenneth R. Thomas Jr.

22. Name and Address of Facility: Thomas Funeral Home PA, 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic heart disease — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: ▶ [signature] M.D

29c. License number: D56659

29d. Date signed (Month, Day, Year): 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MUHAMMAD AFZAL 300 AURORA ST. CAMBRIDGE, MD 21613

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: # 19B PER F.H. G792 2-28-01 WR. *Certificate of Death*

Reg. No. 2001 03202

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margarita N. Bello
2. Date of Death (Month, Day, Year): January 13, 2001
3. Time of Death: 7:40 AM
4a. Facility Name (If not institution, give street and number): 7112 Leyte Drive
4b. City, Town, or Location of Death: Oxon Hill
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-82-1472
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 10, 1908
9. Birthplace (State or Foreign Country): Philippine Isl.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Oxon Hill
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7112 Leyte Drive
10f. Zip Code: 20745
10g. Citizen of What Country? Philippine Islands

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Filipino

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Homemaker

17. Father's Name (First, Middle, Last): Pedro Nartatez
18. Mother's Name (First, Middle, Maiden Surname): Maxima Baltero

19a. Interment's Name/Relationship (Type, Print): Jaime N. Bello - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~Same as item #10~~ 7112 LEYTE DR. ONON HIL MD 20745

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery
Date: 01/18/01
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Geo P. Kalas Jr.
22. Name and Address of Facility: George P. Kalas Funeral Home 6160 Oxon Hill Road, Oxon Hill, Maryland 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Cardiac arrhythmia. 1 year.
Due to (or as a consequence of):
b. Hypertension. > years.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
c. Atherosclerosis heart disease > years
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
asthesitis.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Raman R. Tuli MD
29c. License number: D19609
29d. Date signed (Month, Day, Year): 1-13-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMAN R. TULI MD 3503 PERRY STREET, MT. RAINIER MD 20712

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Sandra G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03203

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES A. COMER
2. Date of Death (Month, Day, Year): jan. 21, 2001
3. Time of Death: 9:40 AM
4a. Facility Name (If not institution, give street and number): 1559 Arena Road
4b. City, Town, or Location of Death: Darlington
4c. County of Death: HArford

Funeral Director

5. Social Security Number: 226-16-1933
6. Sex: ☒ 1 M ☐ 2 F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7/15/1917
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Darlington
10d. Inside City Limits: ☐ 1 Yes ☒ 2 No
10e. Street and Number: 1559 Arena Road
10f. Zip Code: 21034
10g. Citizen of What Country?: USA

11. Marital Status: ☐ 1 Never Married ☐ 2 Married ☒ 3 Widowed ☐ 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☐ 1 Yes ☒ 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ 1 Yes ☒ 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Agriculture

17. Father's Name (First, Middle, Last): Joseph Flem Comer
18. Mother's Name (First, Middle, Maiden Surname): Myrtle Cedella Kegley

19a. Informant's Name/Relationship (Type, Print): Stella M. Miller- daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1616 Poole Rd., Darlington, MD 21034

20a. Method of Disposition: ☒ 1 Burial ☐ 2 Cremation ☐ 3 Removal from State ☐ 4 Donation ☐ 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Mem. Gdns
Date: 1/24/2001
20c. Location - City or Town, State: Bel Air, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Harkins F.H. Inc., 600 Main St., Delta, PA 17314

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Severe COPD — 20 years

Due to (or as a consequence of):
b. Radiation treements for esophageal cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequance of):
c.

Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Esophageal Cancer
Congestive Heart failure

23b. Did tobacco use contribute to the cause of death? ☒ 1 Yes ☐ 2 No ☐ 3 Probably ☐ 4 Unknown

24a. Was an autopsy performed? ☐ 1 Yes ☒ 2 No
24b. Were autopsy findings available prior to completion of cause of death? ☐ 1 Yes ☒ 2 No

25. Was case referred to medical examiner? ☐ 1 Yes ☒ 2 No

26. Place of Death (Check only one)
Hospital: ☐ 1 Inpatient ☐ 2 ER/Outpatient ☐ 3 DOA
Other: ☐ 4 Nursing Home ☒ 5 Residence ☐ 6 Other (Specify)

27. Manner of Death: ☒ 1 Natural ☐ 2 Accident ☐ 3 Suicide ☐ 4 Homicide ☐ 5 Pending investigation ☐ 6 Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? ☐ 1 Yes ☐ 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M. Chatham
29c. License number: D 20907
29d. Date signed (Month, Day, Year): 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marie D. Chatham M.D 615 W. McPhail Rd., Bel Air, MD 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

JAMES ANDREW COMER

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03204

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
MILTON	DASHIELL	COVINGTON	JANUARY 20, 2001	12:35 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
110 S.E. Railroad Ave.	Hebron	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-32-6162	1☒ M 2☐ F	65 Yrs.			October 27,1935	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Hebron	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
110 S.E. Railroad Ave.	21830	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7	-	Boiler Operator	Lumber Mill

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Virgil A. Covington	Ruth Horner

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Betty Cook/Daughter	31835 Essex Place, Delmar, MD 21875

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Hebron Cemetery	1/22/01	Hebron, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ David A. Thompson M01051	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. FAILURE to THRIVE

Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE PULM. DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
CVA

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D32014	1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MAHESH MOONDRA 106 MITFORD ST SUITE B SALISBURY MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 23 2001	▶ [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3 DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #19B PER F.H. G793 3-1-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03205

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Serafin S. Corpuz, Jr.

2. Date of Death — Month: January Day: 16 Year: 2001

3. Time of Death: 6:44 PM

4a. Facility Name (If not institution, give street and number): Fort Washington Hospital

4b. City, Town, or Location of Death: Ft. Washington

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 220-11-7364

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): Oct. 30, 1927

9. Birthplace (State or Foreign Country): Philippine Is.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Oxon Hill

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6482 Bock Road #421

10f. Zip Code: 20745

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Filipino

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cable Splicer Supervisor

16b. Kind of Business/Industry: Telephone Company

17. Father's Name (First, Middle, Last): Serafin S. Corpuz, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Bernarda Santos

19a. Informant's Name/Relationship (Type, Print): Magdalena B. Corpuz/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~Same as item 10~~ 6482 BOCK RD. #421 ONON HILL, MD 20745

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Love Memorial Cemetery

Date: 1/21/2001

20c. Location - City or Town, State: Noveleta Cavite, Philippines

21. Signature of Funeral Service Licensee: George P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure — 5 days

Due to (or as a consequence of):

b. Emphysema

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Barry Redjaee

29c. License number: D39691

29d. Date signed (Month, Day, Year): 1/17/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Barry Redjaee, M.D. 4467 Old Branch Ave. Temple Hills, Md. 20748

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Submit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P.G.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #25 PER PHY G795 5-4-01 WR: **Certificate of Death** Reg. No. 2001 03206

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Lilton Davis		January 13, 2001	6:26 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George's Community Hospital	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-86-6321	1☒ M 2☐ F	40 Yrs.			May 11, 1960	Washington DC

Usual Residance of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Capitol Heights	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
711 Iona Terrace	20743	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3+	Fashion Designer	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lilton Ireland Davis	Pennie T. Edwards

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Pennie Edwards/Mother	711 Iona Terrace, Capitol Heights MD 20743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Harmony Cemetery	1/20/01	Landover, MD

21. Signature of Funeral Service Licensee: ▶ Janice Edwards

22. Name and Address of Facility: Hodges & Edwards Funeral Home, 3910 Silver Hill Road, Suitland MD 20746

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary Embolism	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HIV

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D34569	1/13/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): David Flowers, M.D., 3001 Hospital Drive, Cheverly MD 20745

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	▶ G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

P.G. #25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03207

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leroy Robert Evans
2. Date of Death — Month: January Day: 19 Year: 2001
3. Time of Death: 02:33AM
4a. Facility Name *(If not Institution, give street and number)*: GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-24-2726
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 6, 1928
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 324 Jody Way
10f. Zip Code: 21093
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Attorney
16b. Kind of Business/Industry: Law

17. Father's Name *(First, Middle, Last)*: Leroy Evans
18. Mother's Name *(First, Middle, Maiden Surname)*: Naomi Fleagle

19a. Informant's Name/Relationship *(Type, Print)*: Mary Evans/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 324 Jody Way, Timonium, MD 21093

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Yorktowne Caskets, Inc. Cremation Service — Date: Jan. 20, 2001
20c. Location - City or Town, State: York, PA 17404

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SEPSIS	3 days
Due to (or as a consequence of):		
b.	METASTATIC LUNG CARCINOMA	9 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ACUTE RENAL FAILURE, PROSTATE CANCER

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)* — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Edward E. Kaplan MD
29c. License number: D0055583
29d. Date signed *(Month, Day, Year)*: JANUARY 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DANIEL KAPLAN, MD, 6704 N. CHARLES ST, RM 3853, BALTIMORE, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Evans, Robert L.

X. M.

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #7 PER F.H. G793 3-6-01 WR.

Certificate of Death

Reg. No. 2001 03209

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM ROBERT GIBSON
2. Date of Death (Month, Day, Year): JAN. 17 2001
3. Time of Death: 4:55 PM
4a. Facility Name (If not institution, give street and number): SHORE REHAB & NURSING CENTER
4b. City, Town, or Location of Death: DENTON
4c. County of Death: CAROLINE

Funeral Director

5. Social Security Number: 219-74-6775
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): ~~76~~ 74 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yaar): JULY 6,1924
9. Birthplaca (State or Foreign Country): NEW JERSEY

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CAROLINE
10c. City, Town or Location: DENTON
10d. Inside City Limits: [X] Yes 2 [ ] No
10e. Street and Number: 420 COLONIAL DRIVE
10f. Zip Code: 21629
10g. Citizen of What Country?: USA

11. Marital Status: [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:
13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Raca - Amarican Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completad): Elementary/Secondary (0-12): 0 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A LIFETIME DISABILITY
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middla, Last): WILLIAM H. GIBSON
18. Mother's Name (First, Middle, Maiden Surname): ADA WARE GIBSON

19a. Informant's Name/Relationship (Type, Print): Susan Rogers/ family member
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 100 Twevell Ave. Westville, New Jersey 08093

20a. Method of Disposition: [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Ridgely Cemetery
Date: 1/19
20c. Location - City or Town, Stata: Ridgely, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fleegle- Helfenbein Funeral Home, PA P.O. Box 160 Greensboro, MD 21639

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onsat and Death

Immediate Cause (Finai disease or condition resulting in death): a. Cerebrovascular accident — Due to (or as a consequenca of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b. — Due to (or as a consequence of):
c. — Dua to (or as a consequenca of):
d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension; Dementia

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Piece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residenca 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, streat, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D32036
29d. Date signed (Month, Dey, Year): 1/18/2001

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): Gary J. Sprouse 2108 DiDonato Drive Charter MD 21619

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DR. Gary Sprouse

Cardiac?

1/18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03210

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kenneth Johnson
2. Date of Death Month Day Year: JANUARY 16, 2001
3. Time of Death: 1:45 P.M.
4a. Facility Name *(If not institution, give street and number)*: MALCOLM GROW MEDICAL CENTER
4b. City, Town, or Location of Death: CAMP SPRINGS
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 218-52-6578
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 49 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: January 31, 1951
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Forestville
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1215 Eastwood Dr
10f. Zip Code: 20747
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Technician
16b. Kind of Business/Industry: Coast Guard

17. Father's Name *(First, Middle, Last)*: Ambrose R. Johnson Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Josphine Smith

19a. Informant's Name/Relationship *(Type, Print)*: Chivas Johnson/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1215 Eastwood Dr. Forestville MD 20747

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD Veterans Cem. Date: 1/26/01
20c. Location - City or Town, State: Cheltenham Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: M191 Adams Funeral Home P.A. Aquasco Maryland 20608

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CIRRHOSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. HEPATIC FERLUM

Due to (or as a consequence of):

c. HEPATIC RENAL SYNDROME

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ALCOHOLISM

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: VA 0101040523
29d. Date signed *(Month, Day, Year)*: JANUARY 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORY REHE, COL, USAF, MC
89 MDG/1050 W. PERIMETER RD.
ANDREWS AIR FORCE BASE, MD 20762-6600

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #7 PER F.H. G794 4-5-01 WR. *Certificate of Death* Reg. No. 2001 03211

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Steven Junius Jones
2. Date of Death Month / Day / Year: January 18, 2001
3. Time of Death: 12:25AM
4a. Facility Name *(If not institution, give street and number)*: Doctor's Community Hospital
4b. City, Town, or Location of Death: Lanham, MD
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 231-42-1574
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 90 ~~91~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10-14-1910
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 4402 Keewatin Place
10f. Zip Code: 20706
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Dates: 1944 to 1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Extention Agent
16b. Kind of Business/Industry: Private

17. Father's Neme *(First, Middle, Last)*: Hunter Jones
18. Mother's Neme *(First, Middle, Meiden Surname)*: Cora Stone

19a. Informent's Name/Relationship *(Type, Print)*: Natalie Wallace/Daughter
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4402 Keewatin Pl. Lanham, MD. 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. John Church Cemetery | Date: 1-21-01
20c. Location - City or Town, State: Charles City, Va

21. Signature of Funeral Service Licensee: Lee Mitchell
22. Name end Address of Feciliry: Pope Funeral Homes 5538 Marlboro Pike. Forestville, MD 20747

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. Pneumonia — 3 DAYS
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet Initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the cause(s) end manner steted.

29b. Signature and title of certifier: Bindee Singh
29c. License number: D05666
29d. Date signed *(Month, Day, Year)*: 1-18-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 14300, GALLANT FOX LN, 124, Bowie MD 20715

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 19 2001
32. Registrar's Signeture: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Stevens Junius JONES

P.G.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03212

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louis W Lacurts
2. Date of Death (Month, Day, Year): January 18 2001
3. Time of Death: 3:40 pm
4a. Facility Name (If not institution, give street and number): Deer's Head Center
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 222-03-4690
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/11/18
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WICOMICO
10c. City, Town or Location: WILLARDS
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9321 GREEN BRANCH ROAD
10f. Zip Code: 21874
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CARPENTER
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): JOHN W. LACURTS
18. Mother's Name (First, Middle, Maiden Surname): STELLA WILKINS

19a. Informant's Name/Relationship (Type, Print): ESTHER R. LACURTS/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9321 GREEN BRANCH ROAD, WILLARDS, MD 21874

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETHEL CEMETERY
Date: 1/21/01
20c. Location - City or Town, State: WILLARDS, MARYLAND

21. Signature of Funeral Service Licensee: Charles W Hastings
22. Name and Address of Facility: HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	End Stage Renal Disease secondary to nephrosclerosis	2 years
Due to (or as a consequence of): b.	Coronary artery disease	12 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Peripheral vascular disease	Few weeks
Due to (or as a consequence of): d.	Congestive heart failure	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Tuberculosis of ® hand

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Inja J Hwang MD
29c. License number: D 16003
29d. Date signed (Month, Day, Year): January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): INJA HWANG PO BOX 2018 Salisbury, MD 21802-2018

State Registrar

31. Date filed (Month, Day, Year): JAN 2 3 2001
32. Registrar's Signature: Penny B. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6 DQ

DHMH 16 Rev 6/95

ORIGINAL

01-0339-033
CJ
Raymond Mason

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03213

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond M. Mason
2. Date of Death: Month January, Day 20, Year 2001
3. Time of Death: 06:35 P.M.
4a. Facility Name (If not institution, give street and number): 3841 Saint Barnabas Road
4b. City, Town, or Location of Death: Marlow Heights
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 217-32-2760
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): May 24, 1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 12005 Duley Station Road
10f. Zip Code: 20772
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: American Indian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: Hechinger

17. Father's Name (First, Middle, Last): Joseph Mason
18. Mother's Name (First, Middle, Maiden Surname): Martha Swann

19a. Informant's Name/Relationship (Type, Print): Lewis Mason- brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12005 Duley Station Road Upper Marlboro, Maryland 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Resurrection Cemetery
Date: 1/25/01
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Floyd Estep M191
22. Name and Address of Facility: Adams Funeral Home P.A. Aquasco, Maryland 20608

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Scene

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Margarita Korell
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03214

NAME: MYRTLE E. MACKERT

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Myrtle Elizabeth Mackert

2. Date of Death: Month: JANUARY Day: 23 Year: 2001

3. Time of Death: 7 30 A

4a. Facility Name (If not institution, give street end number): LORIED AT RIVERSIDE

4b. City, Town, or Location of Death: BELCAMP

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 214-20-3832

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 13, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 432 Meadowood Drive

10f. Zip Code: 21040

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Reca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 7 Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Custodian

16b. Kind of Business/Industry: Public School

17. Father's Name (First, Middle, Last): William Bryan Neal

18. Mother's Neme (First, Middle, Meiden Surneme): Mary Elizabeth Adams

19a. Informant's Nama/Relationship (Typa, Print): Debbie L. Johnson / Daughter

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 2109 Brown St., Edgewood, MD 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Placa of Disposition (Nama of cametery, crematory or other pleca): Highview Memorial Gardens Date: 1-26-01

20c. Location - City or Town, State: Fallston, Maryland

21. Signature of Funeral Service Licensee: Stella A. Hughes

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Esophageal cancer

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequanca of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referrad to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledga, daath occurred at tha tima, date and place, end due to the ceuse(s) and menner as stated. 2☐ Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, data and place, and dua to the causa(s) and manner stated.

29b. Signature and title of certifier: Dr. Miller

29c. License number: D27975

29d. Date signed (Month, Dey, Year): 1/23/01

30. Neme end address of person who completed causa of daath (Item 23a) (Type, Print): Dr. Miller MD 615 Macphail rd Bel Air MD 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signeture: B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03215

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy M. Miller
2. Date of Death (Month, Day, Year): January 23 2001
3. Time of Death: 0125
4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 212-26-4852
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 7, 1929
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Cecil
10c. City, Town or Location: Port Deposit
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 16 Maple Hill Drive
10f. Zip Code: 21904
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary/receptionist
16b. Kind of Business/Industry: Clerical
17. Father's Name *(First, Middle, Last)*: Marvin Wakefield
18. Mother's Name *(First, Middle, Maiden Surname)*: Lucy McCleary
19a. Informant's Name/Relationship *(Type, Print)*: Shirley Spence (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7 Birch Ct. Port Deposit, MD 21904
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: R. A. Ferris & Co., Inc.
Date: 1/24/01
20c. Location - City or Town, State: West Chester, PA
21. Signature of Funeral Service Licensee: Kenneth B. Cargo
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Miller, Dorothy 0125 1-23-01

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary artery disease — years

Due to (or as a consequence of):
b. Congestive Heart Failure

Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Arteriosclerotic Cardiovascular disease

Due to (or as a consequence of):
d. Hyperlipidemia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

J.M. 1-23-01

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J T Lee M.D.
29c. License number: D20661
29d. Date signed *(Month, Day, Year)*: 1/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J T Lee M.D. 668 Revolutions St. Havre de Grace MD 21078

10

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03216

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth V. Martin

2. Date of Death (Month, Day, Year): January 21 2001

3. Time of Death: 9:54pm

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-38-2037

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 2, 1940

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7314 TredAvon Road

10f. Zip Code: 21220

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrator

16b. Kind of Business/Industry: Financial

17. Father's Name *(First, Middle, Last)*: John Blondheim

18. Mother's Name *(First, Middle, Maiden Surname)*: Naomi Joy

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Douglas Cook (son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13105 Choptank Road, Baltimore, MD 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith Cemetery

Date: 1/25/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Brian G. Wellen

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. acute respiratory distress syndrome — 8 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Cardiogenic shock — 6 days

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Julia A. Presti DO

29c. License number: AT2438946

29d. Date signed *(Month, Day, Year)*: Jan 21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 201 E. University Pkwy, Balt. MD 21218 Union Memorial Hospital Baltimore MD, Julia Presti DO

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

LM

7

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03217

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY CASSIDY McCAIN

2. Date of Death: Month 1 Day 22 Year 2001

3. Time of Death: 1610

4a. Facility Name (If not Institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 207-14-9757

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 9, 1925

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: ALABAMA

10b. County: JEFFERSON

10c. City, Town or Location: BIRMINGHAM

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 229 HILLMOOR LANE

10f. Zip Code: 35209

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 12 | College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CAREGIVER

16b. Kind of Business/Industry: SELF-EMPLOYED

17. Father's Name (First, Middle, Last): JAMES CASSIDY

18. Mother's Name (First, Middle, Maiden Surname): ELLEN BECKER

19a. Interment's Name/Relationship (Type, Print): THOMAS L. McCAIN - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29658 FOSKEY LANE DELMAR, MD 21875

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ELMWOOD CEMETERY

Date: 1/27/01

20c. Location - City or Town, State: BIRMINGHAM, ALABAMA

21. Signature of Funeral Service Licensee: ▶ B Kent Bynum CFSP

22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 20 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: ▶ MD

29c. License number: D0046080

29d. Date signed (Month, Day, Year): 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Chasse 100 East Carroll Street Salisbury, Md 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001

32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Mary McCain

LDQ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 1 per md G792 2/13/01 yf

Certificate of Death

Reg. No: 2001 03218

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael Williams — Williams, Michael

2. Date of Death: Month 1 Day 30 Year 01

3. Time of Death: 1:43 PM

4a. Facility Name (If not institution, give street and number): Maryland General

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 233-70-7167

6. Sex: XX 1 M 2 F

7. Age (In yrs. last birthday): 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 1, 1945

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX 1 Yes 2 No

10e. Street and Number: 2800 Huntingdon Avenue

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married XX Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No — If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter

16b. Kind of Business/Industry: Contractor Independent

17. Father's Name (First, Middle, Last): Herold Williams

18. Mother's Name (First, Middle, Maiden Surname): Pauline McIntyre

19a. Informant's Name/Relationship (Type, Print): Marion Williams Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1215 Union Avenue, Baltimore, Maryland 21211

20a. Method of Disposition: 1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore-Washington Crematory

Date: 2/2/01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Lynn B. Henss

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc 21211
3631 Falls Road, Baltimore, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Alcohol myopathy

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alcoholic liver disease

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 X Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)

Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. O. [illegible]

29c. License number: 89370

29d. Date signed (Month, Day, Year): January 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. Woodward Dixon C/O Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

ADMEND ITEM: #7 PER F.H. G795 5-15-01 WR.
Amend Item#1,8 perPHYG792 2/28/2001 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03219

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~Laura Fae Mitchell~~ Laura Fae Roland Mitchell

2. Date of Death (Month, Day, Year): Jan. 17 2001

3. Time of Death: 6:50 am

4a. Facility Name (If not institution, give street and number): mariner Health of Bel Air

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-34-1335

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): ~~88~~ 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~July 24, 1914~~ 7-23-14

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Churchville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10 Priestford Road

10f. Zip Code: 21028

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerical

16b. Kind of Business/Industry: County Court

17. Father's Name (First, Middle, Last): Elihu Gideon Roland

18. Mother's Name (First, Middle, Maiden Surname): Etter Eve Lewis

19a. Informant's Name/Relationship (Type, Print): Roland E. Mitchell (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 132 Longcroft Road, Winchester, VA 22602

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Churchville Presbyterina

Date: 1/20/01

20c. Location - City or Town, State: Churchville, MD

21. Signature of Funeral Service Licensee: Kenneth B. Cargo

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Alzhtimer's Dementia — 3 years

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: MD

29c. License number: D34652

29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Haswell 2 North Avenue Bel Air Maryland 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, 4201 Patterson Avenue

HARFORD

Mitchell, Fae

7/8

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMED ITEM: #19B PER F.H. G&93 3-1-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03220

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE J. MARSHALL
2. Date of Death (Month, Day, Year): JAN. 16, 2001
3. Time of Death: 7:55 PM
4a. Facility Name (If not institution, give street and number): POTOMAC VALLEY NURSING HOME
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 374-14-1486
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 27, 1918
9. Birthplace (State or Foreign Country): OHIO

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4201 SOUTHEND RD.
10f. Zip Code: 20853
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yas, Give Year or Dates: 1942-1952
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Raca - American Indian, Black, White, atc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): ORDINANCE OFFICER
16b. Kind of Businass/Industry: U.S. ARMY

17. Father's Name (First, Middle, Lest): GEORGE MARSHALL
18. Mother's Name (First, Middle, Maiden Sumame): BESSIE WOODRING

19a. Informant's Name/Relationship (Type, Print): ANITA MARSHALL/WIFE
19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Code): 4201 SOUTH END RD. ROCKVILLE MD 20853 ~~SAME AS ITEM #10~~

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHAMBERS CREMATORY | Date: 1/18/01
20c. Location - City or Town, Stete: RIVERDALE, MD.

21. Signature of Funerel Service Licensee: W. W. Chambers M00091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., 5801 CLEVELAND AVE. RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on each line. | Approximata Intarval Between Onset and Death

Immediata Cause (Final diseese or condition resulting in death): a. Respiratory failure
Due to (or as e consaquance of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. CHF
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause givan in Part I.: Parkinsons, Hypertension, Osteomyelitis

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Wara autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was casa referrad to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only ona): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha causa(s) and mannar as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) and menner stated.
29b. Signature and title of certifier:
29c. License number: D56219
29d. Date signed (Month, Day, Year): 1/17/01
30. Name and address of person who complated causa of death (Item 23a) (Type, Print): KATARZYNA OSTRZENSKA, M.D. 11906 DARNESTOWN RD., SUITE G, N. POTOMAC, MD. 20878

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001
32. Registrar's Signature: pending D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADMEND ITEM: #10D, PER F.H. G793 3-15-01 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #1, 1/23/01,cwc, Kent Co.

Certificate of Death

Reg. No. 2001 03221

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martin ~~William~~ Edward Newsome
2. Date of Death (Month, Day, Year): January 14, 2001
3. Time of Death: 1:15 p.m.
4a. Facility Name (If not institution, give street and number): 316 Holly Street
4b. City, Town, or Location of Death: Centreville
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 218-14-1810
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Deta of Birth (Month, Dey, Year): December 3, 1921
9. Birthplace (State or Foreign Country): Chestertown, Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Anne's
10c. City, Town or Location: Centreville
10d. Inside City Limits: XX Yes 2 [ ] No
10e. Street and Number: 316 Holly Street
10f. Zip Code: 21617
10g. Citizan of What Country?: USA

11. Merital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): P.B. Installer/Repairman
16b. Kind ot Business/Industry: Communications

17. Father's Name (First, Middle, Last): Lewis Newsome
18. Mother's Name (First, Middle, Maiden Sumame): Margaret Walker

19a. Informant's Name/Ralationship (Type, Print): Doris E. Newsome
19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Coda): 316 Holly Street, Centreville, Maryland 21617

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cametery, cremetory or other pleca): Chester Cemetery
Date: 1/19/2001
20c. Location - City or Town, Stete: Chestertown, MD

21. Signature of Funeral Service Licensee: ▶ Burk J. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 W. Cypress Street, Millington, MD 21651

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or haart failure. List only one cause on each line.

Approximate Intarval Between Onsat and Daath

Immediate Causa (Final disease or condition resulting in daath)
a. COPD / Emphysema — 2 yrs.
Due to (or as a consequenca of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was casa raferred to medicat examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residenca 8 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledge, daath occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurrad at the time, date and placa, and dua to tha cause(s) and manner stated.

29b. Signature and title of cadifier: ▶ MD
29c. License number: D0051735
29d. Date signed (Month, Day, Year): 1/18/01

30. Name and address ot person who completed causa ot death (Item 23a) (Type, Print): Frederick Delboy 6602 Church Hill Road, Suite 200, Chestertown, Maryland 21620

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signatura: ▶ Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03222

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KAREN L. PAIGE
2. Date of Death (Month, Day, Year): January 19 2001
3. Time of Death: 0745
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-80-6216
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 40 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 18, 1961
9. Birthplece (State or Foreign Country): MARYLAND

Usual Residence of Decedant

10a. Stete: MD
10b. County: WICOMICO
10c. City, Town or Location: FRUITLAND
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street end Number: 515 SHELDON AVE.
10f. Zip Code: 21826
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever In U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, Whita, etc. Specify: WHITE

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Neme (First, Middle, Last): CHARLES C. KNIGHT
18. Mother's Neme (First, Middle, Maiden Surname): KAY SMITH

19a. Informent's Neme/Reietionship (Type, Print): JAMES E. PAIGE HUSBAND
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 515 SHELDON AVE. FRUITLAND, MD 21826

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): CAMBRIDGE CREMATORY
Dete: 1-20-2001
20c. Location - City or Town, Stete: CAMBRIDGE, MD

21. Signature of Funarel Service Licensee: Robert M. Fannis
22. Name and Address of Facility: BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused tha daath. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deth

Immedieta Cause (Final disease or condition resulting in deeth): a. Pneumonitis 2° to

Due to (or as a consequence of): b. neutropenia

Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting tn death) Last:

Due to (or es a consequence of): c. Metastatic Ovarian Ca — 6 mo

Due to (or es a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatiant 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the besis of exemination and/or investigetion, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: Joseph A. Graseo MD
29c. License number: D 20507
29d. Dete signed (Month, Day, Year): 1/19/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Joseph A. Graseo 145 E. Carroll St Salisbury MD

State Registrar

31. Date filed (Month, Day, Year): JAN 2 3 2001
32. Registrar's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Karen Paige

Records DAS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03223

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maude Jesse Rice
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 11:57
4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 212-50-2750
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 12, 1908
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2027 S. Fountain Green Road
10f. Zip Code: 21015
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Hillary (u/k) Sheppard
18. Mother's Name (First, Middle, Maiden Surname): Hattie Mae Vannoy

19a. Informant's Name/Relationship (Type, Print): Roger Rice / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 800 St. Andrew's Way W, Bel Air, MD 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion U.M. Cemetery | Date: 1-25-01
20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Stephen A Hughes
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. AORTIC STENOSIS
Due to (or as a consequence of):
c. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: SYED F. MAHMOOD MD
29c. License number: D45921
29d. Date signed (Month, Day, Year): JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SYED F. MAHMOOD 4-B NORTH AVENUE SUITE 302 BEL AIR MARYLAND 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Dr. Mahmood 1/21/01 115 Rice, Maude

8

DHMH 16 Rev 6/95

ORIGINAL

VOID

CERTIFICATE ##

01-3224

SEE

CERTIFICATE ##

00-436628

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03225

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HARVIE L. SIMS,SR.
2. Date of Death (Month, Day, Year): January 24, 2001
3. Time of Death: 1:45 PM
4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital Center
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 253-54-2718
6. Sex: X 1 M 2 F
7. Age *(In yrs. last birthday)*: 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 24,1933
9. Birthplace *(State or Foreign Country)*: Georgia

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: White Plains
10d. Inside City Limits: 1 Yes 2 X No
10e. Street and Number: 10075 Marshall Corner Road
10f. Zip Code: 20695
10g. Citizen of What Country?: USA
11. Marital Status: 1 Never Married 2 Married 3 X Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Biologist
16b. Kind of Business/Industry: Hospital
17. Father's Name *(First, Middle, Last)*: Farris C. Sims
18. Mother's Name *(First, Middle, Maiden Surname)*: Almetie Singleton Sims
19a. Informant's Name/Relationship *(Type, Print)*: Tilda Ferebee/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 1251 White Plains,MD. 20695
20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crossroads Baptist Cem. | Date: 2/2/01
20c. Location - City or Town, State: Toccoa,GA.
21. Signature of Funeral Service Licensee: David C. Echols M00945
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD. 20646

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypotension, Shock

Due to (or as a consequence of):
b. End Stage renal

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Decub. ti

Due to (or as a consequence of):
d. Abdominal distention

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death *(Check only one)*: Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other *(Specify)*

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K. Davachi MD
29c. License number: D25640
29d. Date signed *(Month, Day, Year)*: 01/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kohsro Davachi,M.D. 7801 Old Branch Ave. #409 Clinton,MD. 20735

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2001 03226
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LOUISE BOUNDS STEWART
2. Date of Death Month Day Yaer: JANUARY 19,2001
3. Time of Death: 3:10 AM
4a. Facility Name *(If not institution, give street and number)*: SNOW HILL NURSING AND REHABILITATION CENTER
4b. City, Town, or Location of Death: SNOW HILL
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 214-10-6455
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEPT. 9,1913
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residance of Dacedant

10e. Steta: MARYLAND
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 1016 PHILLIPS AVE.
10f. Zip Coda: 21804
10g. Citizan of What Country?: U.S.A.
11. Meritei Stetus: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Evar in U,S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Yaar or Datas:
13. Wes Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American indian, Black, Whita, atc. *Specify:* WHITE
15. Decedent's Education *(Specify only highast grade completed)*: Elamantary/Secondary (0-12); Collega (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT usa retired)*: SECRETARY
16b. Kind of Businass/Industry: U.S. POSTAL SERVICE
17. Fathar's Nama *(First, Middla, Last)*: WILLIAM F. BOUNDS
18. Mothar's Nama *(First, Middle, Maidan Surnama)*: BESSIE TRUITT
19a. Informent's Name/Ralationship *(Type, Print)*: BARBARA R. TRADER - personal rep.
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 122 E. MAIN ST. SALISBURY, MD 21801
20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*
20b. Placa of Disposition *(Neme of cematary, crametory or othar place)*: PARSONS CEMETERY
Data: 1/23/01
20c. Location - City or Town, Stata: SALISBURY, MARYLAND
21. Signature of Funeral Service Licensee: B. Keith Lynn, CFSP
22. Nema and Addrass of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complicetions that caused the death. Do not antar tha moda of dying, such es cardiec or raspiratory arrast, shock, or haart failura. List only ona cause on aach lina.

Approximata Interval Between Onset and Death

Immedieta Cause (Final disaasa or condition resulting in death): a. End Stage Dementia, Alzheimers Type — 5 yrs
Dua to (or as e consequence of):

Sequantially list conditions, if any, laeding to immadiata cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last:
b. Due to (or as a consequance of):
c. Due to (or es e consequence of):
d.

Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I.: Pneumonia. Chronic Obstructive Pulmonary Disease Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wera autopsy findings available prior to compiation of causa of death? 1☐ Yas 2☒ No

25. Was casa refarred to medical axaminar? 1☐ Yes 2☒ No

28. Placa of Death *(Check only one)*: Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☒ Nursing Homa 5☐ Rasidenca 8☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 8☐ Could not be datarmined

28a. Deta of injury *(Month, Day Year)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At home, farm, straat, factory, offica building, atc. *(Specify)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the causa(s) and manner stated.

29b. Signature and title of certifiar: Gregorio M. Belloso M.D.
29c. Licensa number: D 29505
29d. Date signed *(Month, Day, Year)*: 1-19-2001

30. Nama and address of person who completed cause of death (item 23a) (Type, Print): GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 2 3 2001
32. Registrar's Signatura: Barbara G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DQ 5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #1 PER PHY G794 4-21-01 WR *Certificate of Death*

2001 03227
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~Thompson, Lula~~ LULA THOMPSON

2. Data of Death Month: January Day: 14 Yaer: 2001

3. Tima of Death: 12:25p

4e. Facility Nama (If not institution, giva straat and number): Manor Care

4b. City, Town, or Location of Daath: TOWSON

4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 222-05-4983

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): May 12, 1911

9. Birthplaca (State or Foraign Country): Delaware

Usual Rasidanca of Decadant

10a. Steta: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street end Number: 413 Bradford House

10f. Zip Coda: 21613

10g. Citizan of Whet Country?: United States

11. Maritel Status: 1☒ Naver Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Wes Dacedant of Hispenic Origin? (Specify Yas or No- if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, etc. Specify: Black

15. Decedant's Education (Specify only highest grada completed)

Elamantary/Sacondary (0-12): 8th

Collaga (1-4or 5+):

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Factory Laborer

16b. Kind of Businass/Industry: Crab House

17. Fathar's Nama (First, Middla, Last): Josh Thompson

18. Mothar's Nama (First, Middla, Maidan Surnama): Rachael Benson

19a. Informant's Name/Ralationship (Type, Print): Louis E. Benson Sr (Son)

19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 509 Rossiter Avenue Baltimore MD 21212

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☒ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Name of camatary, cramatory or othar placa): John Wesley Cemetery

Data: Jan. 29 2001

20c. Location - City or Town, Stata: Milford DE

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: Bennie Smith Funeral Home 917 West Isabella St. Salisbury MD 21801

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications thet caused the deeth. Do not enter tha mode of dying, such as cardiac or respiretory arrast, shock, or heart failura. List only ona causa on aach lina.

Approximeta Intarval Batween Onset and Death

Immadiata Causa (Final disaasa or condition resulting in daath)

e. Cancer of Utrine Cervix

Dua to (or as a consequanca of):

Sequantially list conditions, if any, laading to immadieta causa. Entar Underlying Cause (Disaasa or injury that initiated avants resulting in daath) Last

b.

Dua to (or as a consequanca of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to complation of causa of daath? 1☐ Yas 2☒ No

25. Was casa rafarred to medical axaminar? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona)

Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA

Othar: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar (Spacify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarminad

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ Certifying Phyaician: To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ Medical Examinar: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signeture and titla of certifiar: [signature]

29c. Licansa number: D43725

29d. Data signad (Month, Day, Yaer): 1/15/01

30. Nama and addrass of parson who complatad causa of death (Item 23a) (Type, Print): TARIQ MAHMOUD 201-109 Back River Neck Rd Baltimore MD 21221

State Registrar

31. Data filad (Month, Day, Yaar): JAN 19 2001

32. Ragistrar's Signatura: Bennie G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

WLC. CG. #1 5 DQ

RKD

01-0508-017

JESSICA
THOMAS AMEND ITEM 23a,27 per ME G794 041801 SS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03228

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JESSICA NICOLE THOMAS

2. Date of Death (Month, Day, Year): JANUARY 30, 2001

3. Time of Death: 2:10P.M.

4a. Facility Name (If not institution, give street and number): CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death: La PLATA

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 216-49-1878

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 3 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 20, 1997

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Waldorf

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2460 Kenbrook Court

10f. Zip Code: 20603

10g. Citizen of What Country?: USA

11. Marital Status: X☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes X☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 0

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NA

16b. Kind of Business/Industry: NA

17. Father's Name (First, Middle, Last): Douglas D. Thomas

18. Mother's Name (First, Middle, Maiden Surname): Mary Angeline Page

19a. Informant's Name/Relationship (Type, Print): Douglas D. Thomas - Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2460 Kenbrook Ct., Waldorf, MD 20603

20a. Method of Disposition: X☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery

Date: 2-6-01

20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: Mark G. Brohawn M00053

22. Name and Address of Facility: Huntt Funeral Home, P. O. Box 156, Waldorf, MD 20604-0156

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDITIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore K. Fong MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): THEODORE MCKING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03229

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jessie Eleanor Townsend

2. Date of Death (Month, Day, Year): January 22 2001

3. Time of Death: 2:30 pm

4a. Facility Name *(If not institution, give street and number)*: Wicomico Nursing Home

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 214-07-7432

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 21 1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: Fruitland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 812 West Main St.

10f. Zip Code: 21826

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Robert E. Russell

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna E. Lankford

19a. Informant's Name/Relationship *(Type, Print)*: Anna Grace East - daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 812 West Main St., Fruitland, MD 21826

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sharptown Firemans Cemetery | Date: 1-26

20c. Location - City or Town, State: Sharptown, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Thomas Funeral Home PA, 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. chronic renal failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. congestive heart failure

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: fluid overload 2° chronic renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D34145

29d. Date signed *(Month, Day, Year)*: January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Rifkin, M.D. 11 Aston Court, Owings Mills, MD 21117

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #19B PER F.H. G793 3-1-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03230

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDNA M. THOMPSON
2. Date of Death: Month JAN. Day 13, Year 2001
3. Time of Death: 5:45 AM
4a. Facility Name (If not institution, give street and number): COLLINGSWOOD NURSING HOME
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 235-36-4990
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 21,1922
9. Birthplace (State or Foreign Country): W. VA.

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 500 LINCOLN ST.
10f. Zip Code: 20850
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): GROVER HORNICK
18. Mother's Name (First, Middle, Maiden Surname): MARY KIMBLE

19a. Interment's Name/Relationship (Type, Print): ROBERT L. THOMPSON/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 500 LINCOLN ST. ROCKVILLE MD. 20850 SAME AS ITEM #19

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHAMBERS CREMATORY
Date: 1/16/01
20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers MD091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., 5801 CLEVELAND AVE. RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Myocardial infarction — minute
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: dementia; seizure disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David A. Blass MD
29c. License number: D23911
29d. Date signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): David A. Blass MD 9410 Old Georgetown Road Bethesda, MD 20814

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

P.G. copy

(4)

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

APPROVED [illegible] #7 PER FUNERAL HOME G793 3-30-01 WR.

Reg. No. 2001 03231

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Ba	Thi	Trinh	January	5,	2001	7:36 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-23-3218	1☐ M 2☒ F	49 ~~50~~ Yrs.			August 22, ~~1951~~ 1951	Viet Nam

Usual Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9317 Avenel Road	20903	Viet Nam

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Asian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		HOUSEKEEPING	Hotel

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Tan A. Trinh	Xuyen Thi Nguyen

19a. Inlormant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Ly Nguyen Husband	9317 Avenel Road Silver Spring, MD 20903

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)	George Washington Cemetary	01-09-01	Adelphi, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Wanda L. Bacon CCO 361	Bacon Funeral Home, Inc. 3447 14th St., NW Washington, D.C. 20010

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset and Death

Immedlete Cause (Finel disease or condition resulting in death)
a. Myocardial Infarction

Due to (or as a consequence of):
Cardiomyopathy

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the undertying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy lindings available prior to completion ot cause ol death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was cese referred to medical examiner?	26. Place ol Deeth (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) — 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ James K. Lightfoot, M.D.	52326	January 5, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
James K. Lightfoot, M.D. 7600Carroll Avenue Takoma Park, MD 20912

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 17 2001	▶ Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the MedicaI Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03232

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RALPH EDWARD WYLIE, JR.

2. Date of Death (Month, Day, Year): JANUARY 26, 2001

3. Time of Death: 6:49 PM

4a. Facility Name *(If not institution, give street and number)*: SOUTHERN MARYLAND HOSPITAL CENTER

4b. City, Town, or Location of Death: CLINTON

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 248-62-7492

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 28, 1941

9. Birthplace *(State or Foreign Country)*: SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: WALDORF

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8504 ABELL WAY

10f. Zip Code: 20603

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 11; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CARPENTER

16b. Kind of Business/Industry: HOME CONSTRUCTION

17. Father's Neme *(First, Middle, Last)*: RALPH EDWARD WYLIE, SR.

18. Mother's Neme *(First, Middle, Maiden Surname)*: ELLA K. SULLIVAN

19a. Informent's Neme/Reletionship *(Type, Print)*: RALPH E. WYLIE III. - SON

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 788 PORTOLA TERRACE, LOS ANGELES, CALIFORNIA 90042

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Pleca of Disposition *(Name of cemetery, crematory or other place)*: TRINITY MEMORIAL GARDENS

Dete: 1/31/2001

20c. Location - City or Town, Stete: WALDORF, MARYLAND

21. Signature of Fureral Service Licensee: JOHN P. KNISLEY M01164

22. Name end Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156

JPK

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Deeth

Immediete Cause (Finel disease or condition resulting in deeth)

a. Lung Cancer — Approximate Interval: 3 m.

Due to (or es e consequence of):

b. Signs — Approximate Interval: 1 week

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest

Due to (or as a consequenca of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

29c. License number: 045365

29d. Date signed *(Month, Day, Year)*: 1-27-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Sidakous, 6707 Livingston Rd #101, Ft Washington MD 20744

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 2001

32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Wylie, Ralph 1/26/01 @ 1849 Dr. W. Tanner 999683

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#7 perINFG793 3/17/2001 EW

Certificate of Death

Reg. No. 2001 03233

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ella Fitzgerald Williams

2. Date of Death Month: January Day: 2 Year: 2001

3. Time of Death: 1819

4a. Facility Name (If not institution, give street and number): Malcolm Grow Medical Center

4b. City, Town, or Location of Death: Camp Springs

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 104-34-6571

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 59 ~~60~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 18, 1941

9. Birthplace (State or Foreign Country): Wilson, N.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Forestville

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 3115 Newkirk Ave.

10f. Zip Code: 20747

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): John Wimberley

18. Mother's Name (First, Middle, Maiden Surname): Geneva Stith

19a. Informent's Neme/Reletionship (Type, Print): Evangelyn Williams/ Daughter

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3243 B. Cofer Rd. Richmond, Va. 23224

20a. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☒ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Maury Cemetery

Date: 1/12/01

20c. Location - City or Town, Stete: Richmond, Va.

21. Signeture of Funerel Service Licensee: Keith A. Stanley MD1065

22. Name end Address of Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'naturel', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Final diseese or condition resulting in deeth)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner as stated. 2☑ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner steted.

29b. Signeture end title of certifier: Salvador Sylvester, DO

29c. License number: H0055927

29d. Date signed (Month, Day, Year): January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Dete filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

ADH
KENDELL ANDERSON
01-0600-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23a,27,&28a-f per ME 6/92 021401 SS

Certificate of Death

Reg. No. 2001 03234

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KENDALL ANDERSON

2. Date of Death Month Day Year: FEBRUARY 3, 2001

3. Time of Death: 1851 P M

4a. Facility Name (If not institution, give street and number): 206 NORTH CHESTER STREET

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

Funeral Director

5. Social Security Number:

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/7/60

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5107 ARBUTUS AVE.

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UKN

16b. Kind of Business/Industry: UKN

17. Father's Name (First, Middle, Last): EDWARD ANDERSON

18. Mother's Name (First, Middle, Maiden Surname): OLIVIA ANDERSON

19a. Informant's Name/Relationship (Type, Print): EDWARD ANDERSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5107 ARBUTUS AVE. BALTO. MD.21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY

Date: 2/8/01

20c. Location - City or Town, State: BALTIMORE MD.

21. Signature of Funeral Service Licensee: Paul A Estep

22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME 1300 EUTAW PLACE BALTIMORE, MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined

28a. Date of Injury (Month, Day Year): 02-03-01

28b. Time of Injury: unknown M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOUSE

28f. Location (Street and Number or Rural Route Number, City or Town, State): 206 N Chester St., Balt, MD

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Clifton Locke, MD

29c. License number: OCME

29d. Date signed (Month, Day, Year): FEBRUARY 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Clifton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: Penny B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM :#5 PER F.H. G792 2-27-01 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gertrude H. Acton

2. Date of Death: Month: Feb. Day: 3 Year: 2001

3. Time of Death: 03235 5:45 PM

4a. Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: ~~578-10-7063~~ 578 03 1118

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 9, 1918

9. Birthplace *(State or Foreign Country)*: Washington D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: New Carrollton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6506 Lamont Drive

10f. Zip Code: 20784

10g. Citizen of What Country?: United States

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 College (1-4or 5+): 0

16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Russell T. Hite

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Ruth Kuhnert

19e. Informent's Neme/Reletionship *(Type, Print)*: Donald R. Acton Son

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 6900 Winners Circle Fairfax Station VA 22039

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Cedar Hill Cemetery

Dete: 2/8/01

20c. Location - City or Town, Stete: Suitland Maryland

21. Signature of Funerel Service Licensee: Robert E. Evans

22. Neme end Address of Fecility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or compticetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feiture. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Finet diseese or condition resulting in deeth)

a. Sepsis

Due to (or as a consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Last

b. Glioblastoma

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: Jenny May MD

29c. License number: D43260

29d. Date signed *(Month, Day, Year)*: 2/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jenny May MD 13952 Baltimore Ave Laurel MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 07 2001

32. Registrer's Signeture: Lauren G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03236

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Salley Anderson

2. Date of Death (Month, Day, Year): Feb. 02, 2001

3. Time of Death: 13:24

4a. Facility Name (If not institution, give street and number): 1221 Valley Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 219-10-3633

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08-25-26

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 1221 N. Valley Street

10f. Zip Code: 21202

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technician

16b. Kind of Business/Industry: Micro Biology Lab

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Hanna Wells

19a. Informant's Name/Relationship (Type, Print): Guy Stilley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1221 N. Valley Street Baltimore, Maryland 21202

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery

Date: 02-08-01

20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funeral Service Licensee: Francis [illegible]

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. CORONARY ARTERY OCCLUSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CORONARY ARTERIOSCLEROSIS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? ☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes ☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home ☒ Residence 6☐ Other (Specify)

27. Manner of Death: ☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph D. Notarangelo M.D.

29c. License number: DO 7316

29d. Date signed (Month, Day, Year): FEB-5-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH D. NOTARANGELO M.D. 301 ST. PAUL PLACE. BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: [signature]

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03237

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM A. BARRETT

2. Date of Death (Month, Day, Year): JANUARY 25, 2001

3. Time of Death: 8:23 PM

4a. Facility Name (If not institution, give street and number): Gilchrist Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 087-26-7724

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar 13, 1936

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6601 N. Charles Street

10f. Zip Code: 21204

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): +5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): engineer

16b. Kind of Business/Industry: quality control

17. Father's Name (First, Middle, Last): Joseph Arlis Barrett

18. Mother's Name (First, Middle, Maiden Surname): Anna P. Prinzing

19a. Informant's Name/Relationship (Type, Print): Marsha Barrett/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7902 Vintage Circle Glen Burnie, MD 21061

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. lung cancer — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0051926

29d. Date signed (Month, Day, Year): 1/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M Gordon MD 6565 N. Charles St Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: Sharon D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

William B Barrett January 25, 2001 8:23 PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03238

PATIENT KNOWN AS: CHARLOTTE J BAYLUS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charlotte Baylus

2. Date of Death: Month FEBRUARY Day 2 Year 2001

3. Time of Death: 5:05 PM

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

Funeral Director

5. Social Security Number: 197-20-4231

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-26-25

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 3501 Englemeade Rd.

10f. Zip Code: 21208

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): 3 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse

16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): Paul Sarbaugh

18. Mother's Name (First, Middle, Maiden Surname): Mary Worley

19a. Informant's Name/Relationship (Type, Print): Donica Baylus / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8831 Okeechobee Blvd. W. Palm Beach, FL. 33411

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 2/5/01

20c. Location - City or Town, State: Catonsville, MD.

21. Signature of Funeral Service Licensee: ▶ Vaughn C Hess

22. Name and Address of Facility: Cremation Services. PA. 6151 Baltimore Nat'l Pike Balto. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Subdural Hematoma — 1 day

Due to (or as a consequence of):

b. Metastatic Breast Cancer — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ G. E. Salzman MD

29c. License number: RES. 000

29d. Date signed (Month, Day, Year): February 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GUNNAR E SALZMAN, MD SINAI HOSPITAL OF BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03239

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES JEROME BARNES
2. Date of Death: Month 02 Day 04 Year 2001
3. Time of Death: 0748
4a. Facility Name (If not institution, give street end number): DEATON HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-60-5695
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 46 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 28, 1954
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 907 Washington Boulevard
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Private Industry

17. Father's Name (First, Middle, Last): James Barnes
18. Mother's Name (First, Middle, Maiden Surname): Elnora Houze

19a. Informant's Name/Relationship (Type, Print): Elnora Winston/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 727 Druid Park Lake Drive Apt. 14J Baltimore, Md21217

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery
Date: 2-6-01
20c. Location - City or Town, State: Baltimore, maryland

21. Signature of Funeral Service Licensee: Leroy Harris
22. Name and Address of Facility: Chatman-harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	METASTATIC CANCER TO SPINE	4 weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	LUNG CANCER	4 weeks
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D0052749
29d. Date signed (Month, Day, Year): 02/05/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAYANT HIRPARA MD

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

BARNES, JAMES

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03240

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): May Emma Boerum

2. Date of Death: Month February Day 1 Year 2001

3. Time of Death: 11:10 am

4a. Facility Name (If not institution, give street and number): Millennium Health & Rehab. - South River

4b. City, Town, or Location of Death: Edgewater

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-42-0586

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months Days

If Under 24 Hrs.: Hours Min.

8. Date of Birth (Month, Day, Year): Aug. 27, 1905

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: West River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5113 Holly Drive

10f. Zip Code: 20778

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 11 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Manager

16b. Kind of Business/Industry: Montgomery Co. Schools

17. Father's Name (First, Middle, Last): Lewis F. Hobbs

18. Mother's Name (First, Middle, Maiden Surname): Alice Kelly

19a. Informant's Name/Relationship (Type, Print): Donald Alton Boerum (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 601 Orchard Way, Silver Spring, MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Union Cemetery

Date: 02/05 2001

20c. Location - City or Town, State: Burtonsville, MD

21. Signature of Funeral Service Licensee: Patrick J. Arld

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. metastatic carcinoma unknown primary — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

hypothyroidism

coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donna Chambers MD

29c. License number: D48101

29d. Date signed (Month, Day, Year): 2/2/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Donna Chambers 8601 Veterans Hwy Suite 204 Millersville MD 21108

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03241

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
THELMA V. BIANCO	FEBRUARY 05 2001	5:25 PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GENESIS ELDERCARE HAMMONDS LANE	BROOKLYN PARK	ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-07-1688	1☐M 2☒F	88 Yrs.			July 05 1912	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	n/a	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
707 E. Fort Ave.	21230	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10	0	Claims Processor	Commercial Credit

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Milton J. Williams	Anna Mae Micheal

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Angelo C. Bianco (Husband)	707 E. Fort ave. Baltimore, Md. 21230

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Glen Haven Memorial Park	2/09/2001	Glen Burnie, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Leo S. Polyniak	McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Chronic Renal Failure	6 months
Due to (or as a consequence of): b.	Coronary Artery Disease	3 years
Due to (or as a consequence of): c.	Essential Hypertension	10 years
Due to (or as a consequence of): d.	Diabetes Mellitus	15 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Thrombocytopenia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
▶ Harjit Singh M.D.	D0014160	02/06/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 07 2001	▶ Sandra G Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03242

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irvin T. Chalk Jr.

2. Date of Death (Month, Day, Year): Jan. 19, 2001

3. Time of Death: 5:pm

4a. Facility Name (If not institution, give street and number): 9272 Adelphi Road #12

4b. City, Town, or Location of Death: HYattsville

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 224-28-9325

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 4, 1925

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Md.

10b. County: Prince Georges

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9272 Adelphi Road #12

10f. Zip Code: 20783

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Worker

16b. Kind of Business/Industry: Peanut Co.

17. Father's Name (First, Middle, Last): Irvin T. Chalk Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ollie Collins

19a. Informant's Name/Relationship (Type, Print): Jackie C.Little Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9272 Adelphi Road #12 Hyattsville,Md.20783

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Church Cemetery

Date: 1/27/01

20c. Location - City or Town, State: Sulfolk,Va.

21. Signature of Funeral Service Licensee: ▶ Francis B. Hunt

22. Name and Address of Facility: Hunt Funeral Home 908 Kennedy St.N.W.Wash.D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrsythmia — 15 min.

Due to (or as a consequenca of):

b. Coronory Artery Disease — 10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Metastatic Disease — 1 yr

Due to (or as a consequence of):

d. Carcinoma Prostate

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Anemia, Dehydration

Emphysema

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: ▶ [signature]

29c. License number: D 17843

29d. Dete signed (Month, Day, Year): Jan. 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vivek Vaid, M.D. 3311 Toledo Terrace #B102 HYattsville, Md. 20782

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: ▶ [signature]

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03243

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JONDA COTTERMAN
2. Date of Death: Month 02 Day 03 Year 01
3. Time of Death: 0501
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 299-32-0807
6. Sex: 1☐ M 2☒ F XX
7. Age (In yrs. last birthday): 62 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 28, 1938
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Edgewater
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2708 Cassia Drive
10f. Zip Code: 21037
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married XX Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Banker
16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): Edgar Jones
18. Mother's Name (First, Middle, Maiden Surname): Phyrne Albright

19a. Informant's Name/Relationship (Type, Print): (Husband) Andrew G. Cotterman, Sr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2708 Cassia Drive, Edgewater, MD 21037

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lakemont Memorial Gardens — Date: 02/08 2001
20c. Location - City or Town, State: Davidsonville, MD

21. Signature of Funeral Service Licensee: Robert J. Hardesty
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	acute pulm edem	2h
Due to (or as a consequence of):	myocardial infarction	2h
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — b.		
Due to (or as a consequence of):	HTN	year
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe psoriasis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J. LaPenta MD
29c. License number: D11438
29d. Date signed (Month, Day, Year): Feb 05, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL J. LAPENTA MD 600 RIDGELY AVE STE 120 21401-1077.

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03244

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PAULINE H. CROUSE
2. Date of Death Month Day Year: FEBRUARY 04 2001
3. Time of Death: 11:30 PM
4a. Facility Name *(If not institution, give street and number)*: GENESIS ELDERCARE HAMMONDS LANE
4b. City, Town, or Location of Death: BROOKLYN PARK
4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 230-05-7764
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 11, 1922
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 314 Townsend Ave
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembly Worker
16b. Kind of Business/Industry: Calvert Distillery

17. Father's Name *(First, Middle, Last)*: William Pugh
18. Mother's Name *(First, Middle, Maiden Surname)*: Rosabell Bevis

19a. Informant's Name/Relationship *(Type, Print)*: Keith D. Barrack (Nephew)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9605 Longview Dr. Ellicott City, Maryland 21042

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore National Cem.
Date: 02-09-01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John T. Collins
22. Name and Address of Facility: McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave Baltimore, Maryland 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Chronic Renal Failure	6 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Coronary Artery Disease	15 years
	Due to (or as a consequence of): c. Essential Hypertension	35 years
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Disease

Bipolar Disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harjit Singh ATTENDING MD PHYSICIAN.
29c. License number: D0014160
29d. Date signed *(Month, Day, Year)*: 02/05/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 07 2001
32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0347-510
CJ
Perry Collieflower

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03245

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PERRY DEAN COLLIFLOWER
2. Date of Death — Month: January; Dey: 21; Year: 2001
3. Time of Death: 11:13 A.M.
4a. Facility Name *(If not institution, give street end number)*: 227 South Broadway
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: UNK
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 37 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCTOBER 13, 1963
9. Birthplace *(State or Foreign Country)*: OKLAHOMA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 227 SOUTH BROADWAY
10f. Zip Code: 21231
10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Eduction *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 12TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRUCK DRIVER
16b. Kind of Business/Industry: TRUCKING

17. Father's Name *(First, Middle, Last)*: HOWARD S. COLLIFLOWER, JR.
18. Mother's Name *(First, Middle, Maiden Surneme)*: MILDRED SHOWE

19a. Informant's Name/Relationship *(Type, Print)*: MILDRED COLLIFLOWER/MOTHER
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 501 W. MOANA LANE #15 RENO, NEVADA 89509

20a. Method of Disposition: 1☐ Burlel 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: GREENMOUNT CREMATORY — Date: Feb. 7, 2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Donald R. Watson, Jr. #M00612
22. Name and Address of Facility: ALTENBURG FUNERAL HOME, P.A. 6009 HARFORD ROAD BALTIMORE, MD. 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one causa on aach line. — Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death):
a. Gastrointestinal Hemorrhage
Due to (or as a consequence of):
b. Chronic Alcoholism

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contributa to the causs of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of ceuse of daath? 1☒ Yes 2☐ No

25. Was casa referrad to medicel examiner? 1☒ Yes 2☐ No
26. Placa of Daath *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, date and place, and due to tha causa(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: [signature] Medical Examiner
29c. Licensa number: O.C.M.E.
29d. Data signed *(Month, Dey, Year)*: January 22, 2001
30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): JEFFREY LUKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Dey, Year)*: FEB 07 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

ADH
GLADYS CHANEY
01-0615-005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03246

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
GLADYS M. CHANEY	FEBRUARY 4, 2001	2116 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SOUTHBOUND I 83 & RUXTON ROAD	BROOKLANDVILLE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-24-4376	1☐M 2☒F	70 Yrs.					MAY 24, 1930	KY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
FL.	—	JACKSONVILLE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2221 WALKERS GLEN LN.	32246	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	—	CLERK	BANK

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ERNEST GUY	EDITH GUY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BILL ZEE / SON	2221 WALKERS GLEN LN. JACKSON, FL.

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MEADOWRIDGE	2/10/01	BALTO. Co. Md.

21. Signature of Funeral Service Licensee: ▶ Paul M. Stella

22. Name and Address of Facility: HARTLEY MILLER FUNERAL HOME, CHTD. 7527 HARFORD Rd. BALTO. Md 21234

Physician /Medical Examiner

23a. Part I1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MULTIPLE INJURIES	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequenca of): b.	
	Due to (or as a consequenca of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑Yes 2☐No	1☑Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) DOA

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☑Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	2-4-01	2111 P M	1☐Yes 2☑No	MVA AND FIXED PASSENGER IN CAR, IMPACT W. TH

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
ROADWAY	SB I83 & RUXTON RD BALTIMORE CO, MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred el the time, date end place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Wayne McHale MD	OCME	FEBRUARY 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARYLAND A. KOROM 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
FEB 07 2001	▶ Donna D. Sparks

Baltimore, Maryland 21215-0036

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED Item#23a perPHYG792 2/7/2001 EW

Certificate of Death

Reg. No. 2001 03247

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Beatrice Bertha Davis

2. Date of Death Month Day Year: January 17, 2001

3. Time of Death: 6 AM

4a. Facility Name (If not institution, give street and number): 840 Powers Street

4b. City, Town, or Location of Death: Hampden

4c. County of Death:

Funeral Director

5. Social Security Number: 197-24-9649

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/12/1910

9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 840 Powers Street

10f. Zip Code: 21211

10g. Citizen of What Country? U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Vincent Davis

18. Mother's Name (First, Middle, Maiden Surname): Emily Girdchoe

19a. Informant's Name/Relationship (Type, Print): Miriam Jean Davis (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 840 Powers Street Baltimore, MD 21211

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Memorial Gard. Date: 1/18 2001

20c. Location - City or Town, State: Middle River, Maryland

21. Signature of Funeral Service Licensee: Michael C. Zaffiri

22. Name and Address of Facility: Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, MD 21221

M 00938

Physician Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ~~Respiratory failure~~ DEMENTIA — 16 Years ~~4 days~~

Due to (or as a consequence of):

b. RESPIRATORY FAILURE — 4 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rong Zhang M.D.

29c. License number: D 55059

29d. Date signed (Month, Day, Year): Jan. 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 201 E University Parkway Baltimore, MD 21218

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: Geneva D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03248

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARTHUR DINKINS

2. Date of Death: Month January Day 28 Year 2001

3. Time of Death: 3:10 am

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 213-54-4568

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 2, 1945

9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 2214 Etting Street

10f. Zip Code: 21217

10g. Citizen of What Country: USA

11. Marital Status: unk
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No unk
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc.
Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Interment's Name/Relationship (Type, Print): Maryland General Hospital

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 827 Linden Ave Baltimore, MD 21201

20a. Method of Disposition
1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State
4 [ ] Donation 5 [X] Other (Specify): in state

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Liver Disease

Due to (or as a consequence of):
b. Cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Atrial Thrombus

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed?
1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?
1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)
Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death
1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mital Dave

29c. License number: P11903

29d. Date signed (Month, Day, Year): 1/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mital DAVE, M.D. Jo Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ARTHUR DINKINS.

01-0594-510
crn
Kenneth Davis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23,27,& 28a-f per ME 02/16/01 JS

Certificate of Death

Reg. No. 2001 03249

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KENNETH DAVIS
2. Date of Death: Month February Day 03 Year 2001
3. Time of Death: 2:20 P M
4a. Facility Name (If not institution, give street and number): 2233 Orem Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-78-9662
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 39 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 29, 1962
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1812 W. BALTIMORE STREET
10f. Zip Code: 21223
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th
College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
18b. Kind of Business/Industry: PACKING

17. Father's Name (First, Middle, Last): JOE LOUIS DAVIS
18. Mother's Name (First, Middle, Maiden Surname): PATRICIA GREENE

19a. Informant's Name/Relationship (Type, Print): PATRICIA WADDY (MOTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 746 DR. BENJAMIN QUARLES PLACE, BALTIMORE, MD 21201

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY
Date: 2/10/01
20c. Location - City or Town, State: LANSDOWNE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: WYLIE FUNERAL HOME PA
638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese or complicetions that caused the deeth. Do not enter the mode ot dying, such es cardiec or respiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Fine diseese or condition resulting in deeth)
a. NARCOTIC INTOXICATION
Due to (or as e consequenca of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet intieted events resulting in death) Last
b. Due to (or as e consequenca of):
c. Due to (or es e consequenca of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnency 1 [ ] Live birth 2 [ ] Fetal deeth 3 [ ] Ectopic pregnancy 4 [ ] Pregnent et time ot deeth 5 [ ] Other (specify) 9 [ ] Unknown
23d. Dete of delivery Month Dey Year

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probebly 4 [✓] Unknown

24a. Was en autopsy performed? 1 [✓] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one)
Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

27. Menner of Death: 1 [ ] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [X] Could not be determined
28a. Date of Injury (Month, Day Year) found: 2-3-01
28b. Time of Injury found: 2:00 P M
28c. Injury et Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject ingested drugs
28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify): found in house
28f. Location (Street end Number or Rurel Route Number, City or Town, State): 2233 Orem Ave., Balto, MD

29a. Certifier (Check only one) 1 [ ] Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as steted. 2 [X] Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 04, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANN A. KOREN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#26 PER MD. G792 2-7-2001 JAB

Certificate of Death

Reg. No. 2001 03250

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eugenia Ann Duval

2. Date of Death: Month: January Day: 28 Year: 2001

3. Time of Death: 730 Am

4a. Facility Name (If not institution, give street and number): 900 Barbury Place

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213-03-6078

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 26, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8540 Marybeth Way

10f. Zip Code: 21043

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Joseph Rinkus

18. Mother's Name (First, Middle, Maiden Surname): Mary Starinskas

19a. Informant's Name/Relationship (Type, Print): Celeste Korpon - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 900 Barbury Place, Annapolis, Md. 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Pk.

Date: 1/31/01

20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: Jeanne M. Pabon

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Colon Cancer to the Liver — 9 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) DAUGHTERS HOME

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nicholas M. Rentschler MD

29c. License number: D38509

29d. Date signed (Month, Day, Year): January 29 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nicholas M. Rentschler Inter 11065 Little Pheasant Pkwy, Columbia MD 21044

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: Barbara G. Brooks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03251

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nuella E. Fredericks

2. Data of Death — Month: 02 Day: 04 Year: 2001

3. Time of Death: 4:00 AM

4a. Facility Name *(If not institution, give street and number)*: Joseph Richey Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 065-26-5761

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Yaar — Months / Days

If Under 24 Hrs. — Hours / Min.

8. Date of Birth *(Month, Day, Year)*

9. Birthplace *(State or Foreign Country)*: ST. Thomas VI

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yas 2☑ No

10e. Street and Number: 3201 Southgreen Road

10f. Zip Coda: 21244

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☑ No — If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☑ No *Specify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): / College (1-4or 5+): 2 yrs

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LP Nurse

16b. Kind of Business/Industry: Health Care

17. Father's Nama *(First, Middle, Last)*: Franklin Frances

18. Mother's Nama *(First, Middle, Maiden Surname)*: Melina Heath

19a. Informant's Name/Ralationship *(Type, Print)*: Garry E. Fredericks / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3201 Southgreen Rd. Balto. MD. 21244

20a. Mathod of Disposition: 1☑ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: Brookmon Cemetery — Data: 2/14/2001

20c. Location - City or Town, State: ST. Thomas Virgin Islands

21. Signatura of Funaral Service Licensee: Vaughn C Greene

22. Nama and Address of Facility: Vaughn C. Greene Funeral Services 5151 Baltimore National Pike Balto. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on aach line.

Approximata Interval Between Onsat and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. Metastatic Ca of Lungs & Liver — 2y.

Dua to (or as a consequanca of):

b. Primary cancer of small bowel

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in daath) Last

Dua to (or as a consequanca of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco uaa contributa to the causa of death? 1☐ Yaa 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to compiation of cause of death? 1☐ Yas 2☑ No

25. Was casa rafarrad to medical examinar? 1☐ Yes 2☒ No

26. Place of Daath *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and due to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, date and placa, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier: Michael G. Hayes, MD

29c. Licansa number: D 02290

29d. Data signed *(Month, Day, Year)*: 2/4/01

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print): Dr. Michael Hayes 2402 Hemlock Ave. Baltimore, MD 21214

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 07 2001

32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Nuella Fredericks 2/4/01 4 Am

CPS
01-0504-510
CHARLES FELDER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03252

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES FELDER SR.

2. Date of Death (Month, Day, Year): January 30, 2001

3. Time of Death: 14:46

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-26-3406

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 22 1929

9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5412 FAIRLAWN AVE.

10f. Zip Code: 21215

10g. Citizen of What Country?: U S A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yas, Give Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired): CEMENT FINISHER

16b. Kind of Business/Industry: CONTRACTING

17. Fathar's Name (First, Middle, Last): SMITTY FELDER

18. Mothar's Name (First, Middle, Maiden Surname): GERTRUDE BRUNSON

19a. Informant's Name/Ralationship (Type, Print): DELORIS FELDER-WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5412 FAIRLAWN AV. BALTO., MD 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramovel from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Placa of Disposition (Nama of cematary, cramatory or othar placa): Garrison Forest Veteran

Data: 2-08-01

20c. Location - City or Town, Stata: Owongs Mills, Md

21. Signature of Funeral Service Licensee: Blayne B. Keke

22. Name and Address of Facility: MARCH FUN. HOME WEST 4300 WABASH AV. 21215

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gunshot Wounds (2) of Left Chest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year): Final 30 01

28b. Time of Injury: 2 08 PM

28c. Injury at Work? 1 [ ] Yas 2 [X] No

28d. Describe how injury occurred: Subject Shot Self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 5412 Fairlawn Avenue Baltimore Maryland

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [XX] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore McKenzie MD

29c. License number: OCME

29d. Date signed (Month, Day, Year): JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE McKENZIE MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ob-2x1

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03253

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Rowe Fuller

2. Date of Death (Month, Day, Year): February 3, 2001

3. Time of Death: 3:01 PM

4a. Facility Name (If not institution, give street and number): 1312 Nicodemus Road

4b. City, Town, or Location of Death: Reisterstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-46-1679

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 14, 1948

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1312 Nicodemus Road

10f. Zip Code: 21136

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 2 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Elton N. Fuller, Jr.

18. Mother's Name (First, Middle, Maiden Surname): Dollie E. Peltzer

19a. Informant's Name/Relationship (Type, Print): Holly Lynn Barrett Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2941 Bloom Road, Finksburg, MD 21048

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Memorial Gardens

Date: 02/06/01

20c. Location - City or Town, State: Finksburg, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Eline Funeral Home 11824 Reisterstown RD. Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Sudden Cardiac Death	5 min
Due to (or as a consequence of):	b. Atherosclerotic Cardiovascular Disease	1 year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D39296

29d. Date signed (Month, Day, Year): 2/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. Ricketts MD CCGH Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03254

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY CARTZENDAFNER FOX

2. Date of Death (Month, Day, Year): 02 05 2001

3. Time of Death: 320 PM

4a. Facility Name *(If not institution, give street and number)*: Westminster Nursing & Convalescent Home

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 220-16-0417

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 5, 1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 47 Timber Ridge Drive

10f. Zip Code: 21157

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): -0-

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Charles Cartzendafner

18. Mother's Name *(First, Middle, Maiden Surname)*: S. Alverta Fritz

19a. Informant's Name/Relationship *(Type, Print)*: Mr. C. Richard Fox

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 21 Park Avenue Westminster, Maryland 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Pipe Creek Cemetery

Date: 2/8/01

20c. Location - City or Town, State: New Windsor Maryland

21. Signature of Funeral Service Licensee: Ronald E. Eline

22. Name and Address of Facility: Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. URINARY TRACT INFECTION — ONE WEEK

Due to (or as a consequence of):

b. ALZHEIMER'S DEMENTIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA & HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James L. Forsberg, MD

29c. License number: D33561

29d. Date signed *(Month, Day, Year)*: 02/05/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James L. Forsberg, MD 1380 Prospect Way, Suite 114, Eldersburg, MD 21784

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 07 2001

32. Registrar's Signature: Linda D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03255

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia D. Grayson
2. Date of Death (Month, Day, Year): February 4, 2001
3. Time of Death: 11:45PM
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 226-28-3284
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 23, 1922
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7700 Cherry Lane
10f. Zip Code: 20707
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Andy C. Porter
18. Mother's Name (First, Middle, Maiden Surname): Mary F. McGee

19a. Informant's Name/Relationship (Type, Print): Judith E. Troffo Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 517 Buckingham Dr. Stevensville MD 21666

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. View Cemetery
Date: 02-10-01
20c. Location - City or Town, State: Sharpsburg Maryland

21. Signature of Funeral Service License: Robert E. Evans
22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CEREBROVASCULER ACCIDENT	4 DAYS
Due to (or as a consequence of): b.	RESPIRATORY FAILURE	3 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Saadullah Khan MD
29c. License number: D24011
29d. Date signed (Month, Day, Year): 2-5-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAADULLAH KHAN MD 8830 CAMERON CT #403 SILVERSPRING MD 20910

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: Geneva G Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03256

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carol L. Garriott-Parker

2. Date of Death Month Day Year: February 3 2001

3. Time of Death: 6:45 a.m.

4a. Facility Name *(If not institution, give street and number)*: 1625 Shore Drive

4b. City, Town, or Location of Death: Edgewater

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-50-9342

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 23, 1940

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Edgewater

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1625 Shore Drive

10f. Zip Code: 21037

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Legal Secretary

16b. Kind of Business/Industry: Law

17. Father's Name *(First, Middle, Last)*: Bernard M. Shartzer, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen M. Dame

19a. Informant's Name/Relationship *(Type, Print)*: Walter E. Parker (Husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1625 Shore Drive, Edgewater, MD 21037

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Trinity Memorial Gardens

Date: 02/07 2001

20c. Location - City or Town, State: Waldorf, Maryland

21. Signature of Funeral Service Licensee: Patrick J. Arnold

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction 410.9 — immed.

Due to (or as a consequence of):

b. Hypertensive Heart Disease 402.1 — yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William H. Choate, MD

29c. License number: D0001030

29d. Data signed *(Month, Day, Year)*: 5 Feb 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR Wm H. Choate 133 Defense Hwy Ste 112 Annapolis MD

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 07 2001

32. Registrar's Signature: Penny D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03257

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John A. Greene, Sr.

2. Date of Death (Month, Day, Year): January 29, 2001

3. Time of Death: 7:55P.M.

4a. Facility Name (If not institution, give street and number): Future Care of the Chesapeake

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel Co.

Funeral Director

5. Social Security Number: 219-12-3767

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/25/1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: Balto.

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3012 Mardel Ave.

10f. Zip Code: 21230

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist

16b. Kind of Business/Industry: Proctor Silex

17. Father's Name (First, Middle, Last): George W. Greene

18. Mother's Name (First, Middle, Maiden Surname): Emma Yateman

19a. Informant's Name/Relationship (Type, Print): Betty R. Greene (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3012 Mardel Ave. Balto., MD. 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crest Lawn Mem. Gardens

Date: 2/1/01

20c. Location - City or Town, State: Marriottsville, MD.

21. Signature of Funeral Service Licensee: John F. Collins

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Rd. Pasadena, MD. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Right lower lobe Pneumonia	2 weeks
Due to (or as a consequence of): b.	Congestive Heart Failure	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Cerebrovascular accident	Many Years
Due to (or as a consequence of): d.	Hypertension	Many Years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mirza M. Nusairee

29c. License number: D40519

29d. Date signed (Month, Day, Year): 1-30-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MIRZA M. NUSAIREE 7845 OAKWOOD PROF. BLDG. GLENBURNIE MD. 21061

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: Teresa G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03258

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): William Francis Garrett					2. Date of Death Month: February Day: 5, Year: 2001			3. Time of Death: 12:25 AM
4a. Facility Name (If not institution, give street and number): 202 Longcross Road				4b. City, Town, or Location of Death: Linthicum			4c. County of Death: Anne Arundel	
5. Social Security Number: 214-34-5463	6. Sex: 1 ☐ M 2 ☐ F	7. Age (In yrs. last birthday): 69 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): JUNE 15, 1931		9. Birthplace (State or Foreign Country): Maryland	
Usual Residence of Decedent								
10a. State: MD	10b. County: Anne Arundel	10c. City, Town or Location: Linthicum					10d. Inside City Limits: 1 ☐ Yes 2 ☒ No	
10e. Street and Number: 202 Longcross Road		10f. Zip Code: 21090			10g. Citizen of What Country: USA			
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1948-52	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plant Manager			16b. Kind of Business/Industry: Conchemco			
17. Father's Name (First, Middle, Last): Paul L. Garrett					18. Mother's Name (First, Middle, Maiden Surname): Bessie Spencer			
19e. Informant's Name/Relationship (Type, Print): Helen Garrett - wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 202 Longcross Rd., Linthicum, Md. 21090						
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Pk.	Date: 2/08/01		20c. Location - City or Town, State: Elkridge, Md.			
21. Signature of Funeral Service Licensee: ▶ M&K. Marshall		22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075						

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PROGRESSIVE PROSTATE CANCER. — YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D33759	Feb 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ARIF HUSSAIN, 22 S. GREENE ST, BALTIMORE, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 07 2001	Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03259

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy L. Hoster

2. Date of Death (Month, Day, Year): February 6, 2001

3. Time of Death: 4:15 pm

4a. Facility Name (If not institution, give street and number): 15 South Ritters Lane

4b. City, Town, or Location of Death: Owings Mills

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 188-09-2826

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 14, 1918

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15 South Ritters Lane

10f. Zip Code: 21117

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Bendix Corporation

17. Father's Name (First, Middle, Last): Edwin Haag

18. Mother's Name (First, Middle, Maiden Surname): Katherine Roland

19a. Informant's Name/Relationship (Type, Print): Sheila Hoster Daughter in Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 105 South Ritters Lane Owings Mills, MD 21117

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation Serv.

Date: 2/7/01

20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funeral Service Licensee: John A. Skeen

22. Name and Address of Facility: Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Parkinson's Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Raymond Miller MD

29c. License number: D47683

29d. Date signed (Month, Day, Year): 2/7/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Raymond Miller 25 Main Street Suite 200 Reisterstown MD

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To Be Completed by Funeral Director

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

01-0577-510
crm
Scott Johnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03260

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
SCOTT DOUGLAS JOHNSON	February 02, 2001	3:01 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Agnes Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-88-4444	1 [X] M 2 [ ] F	34 Yrs.			Feb 3, 1966	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Anne Arundel	Pasadena	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
261 Eighth St.	21122	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Painter	Jerry Robbins Painting Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert L. Johnson, Sr.	Joan A. Baisley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joan A. Jones (mother)	261 Eighth St., Pasadena, Md. 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Glen Haven Mem Pk	02/07/01	Glen Burnie, Md.

21. Signature of Funeral Service Licensee: Kevin E Ecker

22. Name and Address of Facility: McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Md. 21122

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Coronary artery thrombosis	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Atherosclerotic cardiovascular disease	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stephen S. Radentz, M.D.	O.C.M.E.	February 03, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 07 2001	Penny G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03261

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLIFFORD JOHNSON
2. Date of Death (Month, Day, Year): January 23, 2001
3. Time of Death: 650pm
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 214-86-5235
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 39 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 24, 1961
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 1226 Mosher Street
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): electrician
16b. Kind of Business/Industry: electrical

17. Father's Name (First, Middle, Last): Cleveland Johnson
18. Mother's Name (First, Middle, Maiden Surname): Irene Harris

19a. Informant's Name/Relationship (Type, Print): Louann Johnson/sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 S. Robinson Street Baltimore, MD 21224

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Ischemia
Due to (or as a consequenca of):
b. Severe Acute Anemia
Due to (or as a consequenca of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Massive Gastrointestinal Bleed
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
End Stage Renal Disease, Hepatitis B Virus, Thrombocytopenia, Gram + Sepsis, Intravenous Drug Abuse

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Adams
29c. License number: P 13520
29d. Date signed (Month, Day, Year): 01/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Adams, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: Denise D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Clifford Johnson

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0553-510
CJ
Paul T. Jackson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23a,b & 27per ME G795 031601 SS

Certificate of Death

Reg. No. 2001 03262

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Dey	Year	3. Time of Death
PAUL THOMAS JACKSON, JR.			February	01	2001	03:26 P.M.
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
Harbor Hospital	Baltimore		N/A			

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplece (Stete or Foreign Country)
212-78-2930	1☒M 2☐F	33 Yrs.					Jan.24 1968	Maryland

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	n/a	Baltimore	1☒Yes 2☐No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
1721 S. Hanover Street	21230	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - Americen Indien, Bleck, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7	0	Roofer	Bollinger Roofing Co.

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Paul Thomas Jackson, Sr.	Janet Lynn Schuyler

19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Janet L. Jackson (Mother)	1721 S. Hanover Street, Baltimore, Md. 21230

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)	Glen Haven Memorial Park	2/06/2001	Glen Burnie, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Feclity
George M. Hampton Jr.	McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heert failure. List only one cause on eech line.

		Approximate Interval Between Onset end Deeth
Immediate Cause (Finel disease or condition resulting in death)	a. CARDIAC ARRHYTHMIA	
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last	b. DILATED CARDIOMYOPATHY	
	Due to (or es e consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

IF FEMALE: 23b. Wes decedent pregnent in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnency 4☐Pregnent at time of deeth 5☐Other (specify) 9☐Unknown	23d. Deta of delivery Month Dey Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☑Unknown

24e. Was an autopsy performed? 1☑Yes 2☐No	24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? XX Yes 2☐No	28. Place of Deeth (Check only one) Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Deeth 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? 1☐Yes 2☐No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end menner es steted.
2☒ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to tha ceuse(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
J Pestaner M.D.	O.C.M.E.	February 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 07 2001	Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03263

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Pinkney	Jones	Feb. 04, 2001	2:15pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Ward Personal 306 East 24th Street Touch Group Hm.	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
250-30-9902	1☒ M 2☐ F	73 Yrs.			10-23-27	SC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒ Yes 2☐ No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
306 East 24th Street	21218	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th Grade	NA	Construction	Construction Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Jones	Rovina McCray

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lula Atkins	4 Eden Roc Court Baltimore, Maryland 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metro Crematory	02-09-2001	Catonsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Joseph R. Walters Jr	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sacral area decubitus	2 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cerebro Vascular accident	2 yrs
	Due to (or as a consequence of):	
	c. Seizure disorder	4 yrs
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Group

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Amatun N Naeem MD	D15503	Feb 5 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Amatun N NAEEM, 501 Dolphin St Balto MD 2122

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 07 2001	▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0529-510
Wayne Kenny
mnmr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED# 23,ptII,&27 per ME 031301 SS

Certificate of Death

Reg. No. 2001 03264

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wayne L. Kenny

2. Date of Death Month Day Year: January 31, 2001

3. Time of Death: 1856 p M

4a. Facility Name (If not institution, give street and number): Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-54-4835

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 51 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-21-1949

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD

10b. County: Balto.

10c. City, Town or Location: Woodlawn

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 7028 Yataruba Dr.

10f. Zip Code: 21207

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintance Worker

16b. Kind of Business/Industry: US Postal Service

17. Father's Name (First, Middle, Last): Eugene Kenny

18. Mother's Name (First, Middle, Maiden Surname): Jean Downs

19a. Informant's Name/Relationship (Type, Print): Regina C. Kenny/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7028 Yataruba Dr. Woodlawn, MD 21207

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cramatory or other place): Garrison Forest VA. Date: 2/7/01

20c. Location - City or Town, State: Owings Mills

21. Signature of Funeral Service Licensee: [signature] MD1015

22. Name and Address of Facility: Vaughn C Greene Funeral Service 5151 Balto. Nat'l Pike Balto. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GASTROINTESTINAL HEMORRHAGE ASSOCIATED WITH CIRRHOSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fatal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

NARCOTISM

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Stephen S. Radentz, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): February 01, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: [signature] Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03265

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William H. Kersey
2. Date of Death: Month Jan. Day 31, Year 2001
3. Time of Death: 1:25 pm
4a. Facility Name (If not institution, give street end number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-20-5020
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 5, 1922
9. Birthplace (State or Foreign Country): Brockton, Mass

Usual Residence of Decedent

10a. State: Md.
10b. County: MOntgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7051 Carroll Avenue
10f. Zip Code: 20912
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Clothing

17. Father's Name (First, Middle, Last): John E. Kersey
18. Mother's Name (First, Middle, Meiden Surname): Gladys Reed

19a. Informant's Name/Reletionship (Type, Print): Ardena A.Cowan Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 521 Peabody St.N.W.Wash.D.C.20011

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Riverdale Park Crematory
Date: 2/6/01
20c. Location - City or Town, State: Riverdale, Md.

21. Signeture of Funeral Service Licensee: ▶ Francis B. Hunt
22. Name end Address of Facility: Hunt Funeral Home 908 Kennedy St.N.W.Wash.D.C.20011

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. CEREBROVASCULAR ACCIDENT

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last
Due to (or as a consequence of):
c. PERIPHERAL ARTERY DISEASE
Due to (or es a consequence of):
d. CAROTID ARTERY DISEASE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Steu Tee MD
29c. License number: D46998
29d. Date signed (Month, Dey, Year): JANUARY 31, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): STEVEN TEE MD 3415 HAMILTON ST #1 HYATTSVILLE MD 20782

State Registrar

31. Date filed (Month, Dey, Year): FEB 07 2001
32. Registrer's Signature: ▶ Jeanne B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03266

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THELMA KWEDAR
2. Date of Death: Month FEB, Day 01, Year 2001
3. Time of Death: 03:10AM
4a. Facility Name (If not institution, give street and number): Bon Secours Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 215-10-7011
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 22, 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1930 Wilhelm Street
10f. Zip Code: 21223
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): Nathan Ensey
18. Mother's Name (First, Middle, Maiden Surname): Annie (unknown)

19a. Informant's Name/Relationship (Type, Print): Thelma F. Carder - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 229 S. Calhoun Street, Baltimore, Maryland 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 2/5/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Myocardial Infarction
Due to (or as a consequence of):
b. Hypertension
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Seizure disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D21649
29d. Date signed (Month, Day, Year): Feb 02, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SANDANDAR BASKARAN, 3455 Wilkens Ave. Baltimore MD 21229

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03267

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Su IL KWON

2. Date of Death (Month, Day, Year): FEBRUARY 5, 2001

3. Time of Death: 10:11 Am

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: AA COUNTY

Funeral Director

5. Social Security Number: 212-15-6615

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 2, 1924

9. Birthplace (State or Foreign Country): Korea

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 4 Pebble Drive

10f. Zip Code: 21225

10g. Citizen of What Country? Korea

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Oriental Other

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Police Officer

16b. Kind of Business/Industry: Republic of Korea

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Tyrus C. Roger (Son-in-Law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Pebble Drive Baltimore, Maryland 21225

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory

Date: 2/8/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave Baltimore, Maryland 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Chronic Obstructive Lung Disease — years

Due to (or as a consequence of):

b. Cerebrovascular Accident — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D19512

29d. Date signed (Month, Day, Year): 2-5-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SANKS & DOFF MD 1600 Crain Highway - Suite 206 Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

KWON SU I

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03268

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN KREIMER
2. Date of Death (Month, Day, Year): FEBRUARY 2, 2001
3. Time of Death: 4:15 PM
4a. Facility Name (If not institution, give street and number): HERITAGE HARBOR HEALTH & REHAB CENTER
4b. City, Town, or Location of Death: ANNAPOLIS
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 192-05-3198
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 28, 1906
9. Birthplace (State or Foreign Country): N.J.

Usual Residence of Decedent

10a. State: MD
10b. County: ANNE ARUNDEL
10c. City, Town or Location: CROFTON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1727 PEARTREE LANE
10f. Zip Code: 21114
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): HENRY ABRAMS
18. Mother's Name (First, Middle, Maiden Surname): CARRIE HARRIS

19a. Informant's Name/Relationship (Type, Print): STEPHEN KREIMER / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1727 PEARTREE LANE - CROFTON, MD 21114

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): TEMPLE SINAI MEMORIAL PARK | Date: 2/2/01
20c. Location - City or Town, State: PLUM BORO, PA

21. Signature of Funeral Service Licensee: ▶ Jay Alan Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY FIBROSIS
Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶
29c. License number: 00056420
29d. Date signed (Month, Day, Year): 02/06/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter Wagner, 4203 QUEENSBURY RD, Hyattsville, MD 20781

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: ▶ G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03269

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Landreth B. Luck Louison
2. Data of Death (Month, Day, Year): Jan. 19, 2001
3. Time of Death: 3:54 am
4a. Facility Name *(If not Institution, give street end number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-74-9992
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Jan.24,1947
9. Birthplace *(State or Foreign Country)*: West Indies

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 8525 11th Avenue
10f. Zip Code: 20903
10g. Citizen of Whet Country?: U.S.A.

11. Marifal Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Datas:
13. Was Decedenf of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* Black

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usuel Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Plaster
16b. Kind of Business/Industry: Colbert Co.

17. Father's Name *(First, Middle, Last)*: Garvey Louison
18. Mother's Name *(First, Middle, Meiden Sumame)*: Marion Nelson

19a. Informant's Name/Relationship *(Type, Print)*: Shirley S.Louison Wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 8525 11th Ave.Silver Spring,Md.20903

20a. Method of Disposition: ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or othar piece)*: Lincoln Memorial Cem.
Date: 1/25/01
20c. Location - City or Town, State: Suitland,Md.

21. Signeture of Funeral Service Licensee: ▶ Francis B. Hunt
22. Neme end Address of Fecility: Hunt Funeral Home 908 Kennedy St.N.W.Wash.D.C.20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrast, shock, or heert failure. List only one causa on eech line.

Approximete Interval Between Onset and Death

Immediafa Cause (Final diseese or condition resulting in deeth)
a. Sepsis — 2 days

Due to (or as a consequence of):
b. Liver Transplant — years

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last
Due to (or es e consequence of):
c.
Due fo (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceuse given in Part I.
Chronic Renal Failure
Chronic Pleural Effusion

23b. Did tobacco use contribute to the causa of death? 1 ☐ Yas 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Menner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Routa Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and menner es stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, dete and place, and due to the cause(s) end menner stated.

29b. Signatura and fitle of certifier: ▶ MD
29c. Licansa number: D 21340
29d. Data signed *(Month, Day, Year)*: JAN 27, 2001

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): 3941 FERRARA DR WHEATON, MD 20906, RAYMOND A. BASS, M.D.

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 07 2001
32. Registrar's Signatura: ▶ Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03270

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marjory E. Long

2. Date of Death (Month, Day, Year): February 2nd 2001

3. Time of Death: 12:10 AM

4a. Facility Name (If not institution, give street and number): Mariner Health of North Arundel

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 242-32-1762

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 20, 1912

9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8101 Dewberry Circle Apt. 1605

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- II Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Receptionist

16b. Kind of Business/Industry: Doctor's Office

17. Father's Name (First, Middle, Last): Walter E. Deal

18. Mother's Name (First, Middle, Maiden Surname): Selma Staton

19a. Interment's Name/Relationship (Type, Print): Edgaranne Moody (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8101 Dewberry Circle Apt. 1605 Pasadena, Md 21122

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Wesley Chapel Cemetery

Date: 2/7/01

20c. Location - City or Town, State: Dillard, Georgia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D51596

29d. Date signed (Month, Day, Year): FEBRUARY 3rd 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. AMBALAVANAR 716 MAIDEN CHOICE LANE CATONSVILLE MD 21228.

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03271

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carroll George Moals

2. Date of Death Month Day Year: Feb. 3, 2001

3. Time of Death: 3:45 P. M

4a. Facility Name (If not institution, give street and number): Genesis Eldercare-Loch Raven

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-12-9781

6. Sex: 1 X M 2 F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 2, 1908

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 X Yes 2 No

10e. Street and Number: 343 Hillen Road

10f. Zip Code: 21286

10g. Citizen of What Country?: USA

11. Marital Status: Unknown
1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes X No Specify:

14. Race - American Indian, Black, White, etc.
Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 5th grade
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Baltimore County Department of Highways

17. Father's Name (First, Middle, Last): Mervin Moals

18. Mother's Name (First, Middle, Maiden Surname): Mary Armstrong

19a. Informant's Name/Relationship (Type, Print): Amy Davis / friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 343 Hillen Road Towson, Maryland 21286

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Stevenson AME Church Cemetery

Date: 2/8/2001

20c. Location - City or Town, State: Sparks, Maryland

21. Signature of Funeral Service Licensee: ▶ Ebony Harris

22. Name and Address of Facility: Chatman-Harris Funeral Home
5240 Reisterstown Road Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CVA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. senile Dementia — years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. — years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PVD leading factor to Renal malnutrition PVD s/p amputation of toes

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

28. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 X Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Martha C. Raymundo MD

29c. License number: 054518

29d. Date signed (Month, Day, Year): 2/7/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): martha c. raymundo 3007 E Northern Parkway Baltimore MD 21214

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification; To Be Completed by Physician/Medical Examiner

3

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03272

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Judy	Marie	Mills	February	6	2001	4:25 aM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
950 School Lane	Gambrills	Anne Arundel

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-40-7655	1☐M 2☒F	58 Yrs.					Oct. 15, 1942	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Gambrills	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
950 School Lane	21054	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Secretary	Medical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Maurice A. Bullis	Marie Shipe

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michael Babel (Son)	950 School Lane, Gambrills, MD 21054

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Maryland Veterans Cem	02/09 2001	Crownsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Babel J Bullis	Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Ovarian Cancer	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. Selouich, MD	D19838	2/6/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart E. Selouich, M.D. 900 Bestgate Rd. Annapolis, Md.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 07 2001	▶ D. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03273

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Sue Cannaday McDonough

2. Dete of Death — Month: February Dey: 06, Year: 2001

3. Time of Death: 4:10P.M.

4a Facility Name *(If not institution, give street end number)*: Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 213-32-2914

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 66 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: February 09, 1934

9. Birthplace *(Stete or Foreign Country)*: Newport News, VA.

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 33 Murray Hill Circle

10f. Zip Code: 21212

10g. Citizen of What Country?: United States of America

11. Marital Status: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Was Dacedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yeer or Detes:

13. Was Decedent of Hispanic Origin? *(Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)*: 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+): 2

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Zera Cannaday

18. Mother's Neme *(First, Middle, Maiden Surname)*: Emma Hancock

19e. Informant's Name/Relationship *(Type, Print)*: Mr. James R. McDonough (Husband)

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 33 Murray Hill Circle Baltimore, Maryland 21212

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other piece)*: Hilltop Service Corporation

Date: 02/07/2001

20c. Location - City or Town, Steta: Towson, Maryland

21. Signeture of Funerel Service Licensee: Jeffrey L. Gair, Sr. Jeffrey L. Gair, Sr.

22. Name end Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death): a. Pancreatic cancer — 1 year

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last:

b. Due to (or es a consequence of):

c. Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et tha time, date end piece, and dua to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: W. Anthony Riley MD

29c. License number: D25225

29d. Dete signed *(Month, Day, Year)*: February 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 07 2001

32. Registrar's Signature: Lorraine G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4:10 PM

McDonough, Sue 2/6/01

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03274

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month / Day / Year	3. Time of Death
LEONA		MICHAELS	FEBRUARY 4, 2001	10:45PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
STELLA MARIS HOSPICE	TIMONIUM	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
084-01-5768	1☐ M 2☒ F	82 Yrs.			APR.6,1918	N.Y.

Usual Residence of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	LUTHERVILLE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24 WESTSPRING WAY	21093	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		BOOKKEEPER	INSURANCE

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
SAMUEL	LIPSTEIN	CLARA	GREENBERG

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SUSAN GRILLI / NIECE	24 WESTSPRING WAY - LUTHERVILLE, MD 21093

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	HILLTOP SEVICE CORPORATION	2/6/01	TOWSON, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Scott M. Cattle	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha death. Do not antar the mode of dying, such es cardiac or raspiratory arrest, shock, or heart failure. List only ona causa on aach lina.

		Approximate Interval Between Onsat and Death
Immediata Causa (Final diseasa or condition rasulting in death)	a. Cerebrovascular Accident	
	Dua to (or as a consequence of):	
Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury thet initiated events rasulting in death) Last	b.	
	Dua to (or as a consequance of):	
	c.	
	Dua to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was casa rafarrad to medical examiner?	26. Place of Death (Check only ona)	
1☐ Yas 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Othar (Specify) Hospice

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	
	28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)			28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

29a. Cartifier (Check only one) 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurred et the tima, date and place, end due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, daath occurred et the tima, date and place, and due to tha cause(s) and mannar stated.

29b. Signatura and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
▶	D43725	February 5, 2001

30. Name and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
FEB 07 2001	ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

February 4, 2001 10:45 p.m.

Leona Michaels

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03275

Physician /Medical Examiner

1. Decadent's Nama (First, Middle, Last): Peter Nelson

2. Data of Death — Month: January Day: 31st Year: 2001

3. Tima of Death: 1:25 PM

4a. Facility Nama (If not institution, giva streat and number): Harford Gardens N.H.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Numbar: 248-12-0850

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 83 Yrs.

If Under 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Yaar): 5-8-1917

9. Birthplaca (Stata or Foraign Country): S.C.

Usual Rasidanca of Decedent

10a. Stata: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 2125 Penrose Avenue

10f. Zip Coda: 21223

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:

14. Race - Amaricen Indian, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highast grada completed)

Elamantary/Secondary (0-12): 12th grade

Collaga (1-4or 5+): NA

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Home Maker

16b. Kind of Businass/Industry: Home

17. Fathar's Nama (First, Middla, Last): Jake Manigault

18. Mothar's Name (First, Middla, Maidan Surnama): Hattie Manigault

19a. Informant's Name/Relationship (Type, Print): Renita Thrower Daughter

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 6815 Sturbridge Dr. Apt D Balto, Md 21234

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): King Mem Park

Data: 2-6-01

20c. Location - City or Town, Stata: Randallstown, Md 21215

21. Signatura of Funaral Sarvica Licansaa:

22. Nama and Addrass of Facility: March F.H. West 4300 Wabash Avenue Balto, Md

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or haart tailura. List only ona cause on each lina.

Approximata Interval Batwaan Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)

a. Myocardial Infarction

Due to (or as a consequanca of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiatad avants rasulting in daath) Last

b.

Due to (or as a consequanca of):

c.

Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yas 2☒ No

25. Was casa ratarrad to medical exeminer? 1☐ Yas 2☒ No

28. Placa of Death (Check only one)

Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA

Other: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Manner of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar):

28b. Tima of Injury: M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, tarm, straat, tactory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, State)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowladga, death occurrad at the time, data and placa, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examinar:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and due to the cause(s) and mannar stated.

29b. Signatura and title of cartifiar: Josiah Tripuraneni

29c. Licansa number: D 30661

29d. Data signed (Month, Day, Yaar): January 31st 2001

30. Nama and addrass of parson who completed cause of daath (Item 23a) (Type, Print): Sreesh TRIPURANENI 4700 Harford Rd. Baltimore Md - 21214

State Registrar

31. Data filad (Month, Day, Yaar): FEB 07 2001

32. Registrar's Signatura: B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylend Department of Health and Mantal Hygiena. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that tha death certificate be executed within 24 hours aftar daath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be datachad for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03276

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONALD PETTY
2. Date of Death (Month, Day, Year): JANUARY 30 2001
3. Time of Death: 18:24
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

Funeral Director

5. Social Security Number: 213-34-3513
6. Sex: [X] M [ ] F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 08, 1937
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: [X] 1 Yes [ ] 2 No
10e. Street and Number: 1606 N. MILTON AVENUE
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: [ ] 1 Never Married [X] 2 Married [ ] 3 Widowed [ ] 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? [ ] 1 Yes [X] 2 No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): [ ] 1 Yes [X] 2 No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): CUSTODIAN
16b. Kind of Business/Industry:

17. Father's Neme (First, Middle, Last): George Petty SR.
18. Mother's Neme (First, Middle, Maiden Surneme): Louise BLACK

19a. Informent's Neme/Reletionship (Type, Print): MARIA M. Petty / WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1606 N. Milton Ave BALTO, MD 21213

20a. Method of Disposition: [X] 1 Burial [ ] 2 Cremetion [ ] 3 Removel from State [ ] 4 Donetion [ ] 5 Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, crematory or other piece): Arbutus Cemetery
Date: 2/5/01
20c. Location - City or Town, Stete: BALTO, MD

21. Signeture of Funerel Service Licensee: Vaughn C Greene
22. Name and Address of Facility: VAUGHN C. Greene Funeral Services, P.A. 5151 BALTO NAT'L PIKE BALTO, MD 21229

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Final disease or condition resulting in deeth)
a. TRANSITIONAL CELL CARCINOMA OF UROTHELIUM — 7/8 MONTHS
Due to (or as e consequenca of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest
b. METASTATIC TO LUNG
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
REACTIVE AIRWAY DISEASE

23b. Did tobacco use contribute to the cause of death? [X] 1 Yes [ ] 2 No [ ] 3 Probably [ ] 4 Unknown

24a. Wes en autopsy performed? [ ] 1 Yes [X] 2 No
24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [X] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No

26. Place of Deeth (Check only one): Hospitel: [ ] 1 Inpatient [X] 2 ER/Outpatient [ ] 3 DOA | Other: [ ] 4 Nursing Home [ ] 5 Residenca [ ] 6 Other (Specify)

27. Menner of Deeth: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending investigation [ ] 6 Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? [ ] 1 Yes [ ] 2 No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office buiiding, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): [X] 1 **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner es stated. [ ] 2 **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to tha ceuse(s) end menner steted.

29b. Signeture and title of certifier:
29c. License number: D42979
29d. Date signed (Month, Dey, Year): FEBRUARY 01, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MICHAEL CARDUCCI MD 601 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrer's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

UNK 01-028
01-603-005
JVW

TERRELL D. PIERson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ADMEND ITEMS: # 17, 18 PER FUNERAL HOME G793 3-13-01 WR.

1- For State Registrar AMENDED ITEMS#23a,27,& 28a-f per ME G792 021401 SS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03277

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
TERRELL PIERSON		FEBRUARY 03, 2001	10:03 P.M.
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
NORTHWEST HOSPITAL CENTER	RANDALLSTOWN	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
22072 6996	1 X M 2 F	25 Yrs.			8/15/75	MD.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.		BALTIMORE	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3805 LEWIN AVE,	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	AFRO Specify: AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	CUSTODIAN	S.E.S AGENT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
~~TYRONE EDWARD TRACY~~ EDWARD PIERSON	ANDRA LYNN PIERSON ~~MARGARET PIERSON~~

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARGARET PIERSON	3805 LEWIN AVE. BALTO. MD. 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	MT ZION CEMTERY	2/09/01	BALTIMORE MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Paul A Estep	ESTEP BROTHERS FUNERAL HOME 1300 EUTAW PLACE BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. NARCOTIC INTOXICATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 No	1 X Yes 2 No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 X Yes 2 No	Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 X Could not be determined	2-3-01	unknown M	1 Yes 2 X No	unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
unknown	unknown

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	O.C.M.E.	FEBRUARY 04, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
J-LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 07 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

NAME KNOWN TO PHYSICIAN: PUMPHREY, HOWARD S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03278

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Howard S. Pumphrey
2. Date of Death Month Day Year: FEBRUARY 5, 2001
3. Time of Death: 10:50PM
4a. Facility Name *(If not institution, give street and number)*: VA MARYLAND HEALTH CARE SYSTEM
4b. City, Town, or Location of Death: PERRY POINT
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 220-14-7361
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 19, 1926
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Delaware
10b. County: Sussex
10c. City, Town or Location: Selbyville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12 West White Tail Drive
10f. Zip Code: 19975
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yeer or Detes: 1944 1946
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8 | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic
16b. Kind of Business/Industry: Auto

17. Father's Neme *(First, Middle, Last)*: Earl Pumphrey
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Anne Meyers

19a. Informent's Neme/Reletionship *(Type, Print)*: Sue Miller (Daughter)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 32447 Johnson Road Salisbury Maryland 21804

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other placa)*: Greenmount Crematory | Date: 2/8/01
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funerel Service Licensee: John T Collins
22. Name end Address of Fecility: McCully-Polyniak Funeral Home, P.A. 130 East Fort Ave Baltimore, Maryland 21230

Physician /Medical Examiner

23a. Pert I: Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Deeth

Immediate Ceuse (Finel diseese or condition resulting in death): e. CARCINOMA OF LUNG WITH BRAIN METASTASIS — UNKNOWN

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as e consequenca of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Raj
29c. License number: D20215
29d. Dete signed *(Month, Day, Year)*: FEBRUARY 5, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): KARMACHANDRA NAIR, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 07 2001
32. Registrer's Signeture: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03279

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Lottie Lucille Riley
2. Dete of Deeth — Month: February — Dey: 2 — Year: 2001
3. Time of Death: 1:10 P.M.
4a Facility Name *(If not Institution, give street end number)*: Cherry Lane Nursing Center
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Sociel Security Number: 578 10 4721
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthdey)*: 83 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: Jan. 29, 1918
9. Birthplace *(State or Foreign Country)*: Virginia

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Churchton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5603 Tiffany Drive
10f. Zip Code: 20733
10g. Citizen of Whet Country?: United States
11. Meritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Reca - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)* — Elementery/Secondary (0-12): 12 — Collega (1-4or 5+): 0
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Director
16b. Kind of Businass/Industry: D.C. Government
17. Fether's Nama *(First, Middle, Last)*: Francis Issac Mullin
18. Mothar's Nama *(First, Middle, Maiden Surname)*: Mabel Ward Warren
19e. Informent's Neme/Reletionship *(Type, Print)*: Herman E. Riley, Jr. Son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 5603 Tiffany Drive Churchton Maryland 20733
20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Cedar Hill Cemetery
Dete: 2/6/2001
20c. Location - City or Town, Stete: Suitland Maryland
21. Signature of Funeral Service Licensee: Robert E. Evans
22. Neme end Address of Fecility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one causa on eech lina.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Final diseese or condition resulting in death): e. Billateral Pneumonia — 1 month
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last:
b. Chronic Obstructive Pulmonary Deseare — 3 years
Due to (or as e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, streat, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceusa(s) and mennar es steted. 2☐ **Medicel Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: M.D
29c. License number: D 24721
29d. Dete signed *(Month, Dey, Year)*: Feb 5th 2001

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): SYED SAAD 14333 Laurel Bowie Road, LAUREL, MD 20708

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: FEB 07 2001
32. Registrer's Signeture: Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #26 PER PHY G792 2-7-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03280

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Willis James Reese	Feb. 02, 2001	8:15am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3306 Piedmont Avenue	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
229-34-6160	1☒M 2☐F	68 Yrs.					08-12-32	VA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☐Yes 2☐No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3306 Piedmont Avenue	21216	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married XX 3☐Widowed 4☐Divorced	X☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade	NA	Imfantry Sergent	Army

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Fred Douglas Norwood	Azlean Perkins

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133
Rhonda R. Darden	3835 Brownhill Road Randallstown, MD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX☒Burial 2☐Cramation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Baltimore Nat'l Cem.	02-08-01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Joseph R. Walter Jr	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. LUNG CANCER	4 MONTHS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☑Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)	
1☑	**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐	**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Ivan Axentijevich M.D.	D0055216	FEBRUARY 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
IVAN AXENTIJEVICH, JOHNS HOPKINS HOSPITAL, BALTIMORE, MD 21231

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 07 2001	Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

95-10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03281

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN SILVER
2. Date of Death: Month February Day 3 Year 2001
3. Time of Death: 15 55
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 231-28-5118
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02 05 28
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedant

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 3703 North Rogers Ave
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 ☐ Never Married X Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedant's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 10th grade; College (1-4or 5+): na
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Businass/Industry: Bethlehem Steel Corp
17. Father's Name (First, Middle, Last): Willis Silver
18. Mother's Neme (First, Middle, Maiden Surname): Luvenia Rudd
19a. Informent's Neme/Relationship (Type, Print): Esther Silver- Wife
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3703 North Rogers Ave, Baltimore Md 21207
20a. Method of Disposition: 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Woodlawn Cemetery
Date: 2/8/01
20c. Location - City or Town, Stete: Baltimore Co., Md
21. Signeture of Funerel Service Licensee: ▶ Willie Edmond
22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory erresl, shock, or haert failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immedieta Causa (Finel disease or condition resulting in death)
e. CARDIOGENIC SHOCK — 3days

Due to (or es e consequance of):

Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last
b. coronary artery disease

Due to (or es e consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Data of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: ▶ Evan Jacobson, MD
29c. License number: X 26683
29d. Date signed (Month, Dey, Year): February 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EVAN L. JACOBSON

State Registrar

31. Data filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signatura: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
DONNISHA STANBACK
01-0580-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23a,b,pt II,27,& 28a Certificate of Death

Reg. No. 2001 03282

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONNISHA D. STANBACK

2. Data of Death Month Day Yaer: FEBRUARY 2, 2001

3. Tima of Death: 1817 PM

4a. Facility Nama (If not institution, giva street and number): JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Daath: BALTIMORE CITY

4c. County of Death: NA

Funeral Director

5. Social Security Number: 213-55-0005

6. Sex: 1☐M 2☒F

7. Aga (In yrs. last birthday): 1 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): MARCH 24, 1999

9. Birthplace (Stata or Foreign Country): MD

Usual Rasidance of Decedent

10a. Stata: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒Yas 2☐No

10e. Street and Number: 344 S. MASON COURT

10f. Zip Coda: 21231

10g. Citizan of What Country?: USA

11. Marital Status: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐Yas 2☒No If Yes, Give Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1☐Yas 2☒No Specify:

14. Race - Amarican Indian, Black, White, etc. AFRICAN Specify: AMERICAN

15. Decedent's Education (Specify only highast grade compiated): Elementary/Secondary (0-12): n/a; College (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): n/a

18b. Kind of Businass/Industry: n/a

17. Father's Name (First, Middle, Last): DONYAL R. STANBACK

18. Mothar's Nama (First, Middla, Maidan Sumame): PATRICIA A. STEWART

19a. Informant's Name/Ralationship (Type, Print): PATRICIA A. STEWART

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 344 S. MASON COURT BALTIMORE, MD 21231

20a. Mathod of Disposition: 1☒ Buriat 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Nama of cematary, cramatory or othar placa): DELANEY VALLEY CEMETERY Data: 2/9/01

20c. Location - City or Town, Stata: BALTIMORE, MD

21. Signatura of Funaral Service Licansee:

22. Nama and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

C

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complicetions thet caused the deeth. Do not antar the moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaen Onsat and Daath

Immediata Causa (Final diseese or condition resulting in death):
a. ASPHYXIA
Dua to (or as a consequance of):
b. AIRWAY OBSTRUCTION BY FOOD BOLUS

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaasa or injury that initiated events resulting in death) Last
Dua to (or as a consequenca of):
c.
Dua to (or as a consequanca of):
d.

IF FEMALE:
23b. Was decedent pregnant in tha past 12 months? 1☐Yas 2☐No 9☐Unknown

23c. If yes, outcoma of pregnancy 1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Othar (specify) 9☐Unknown

23d. Data of dalivery Month Day Year

Part II. **Other significant condttions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: CEREBRAL PALSY; ASTHMA

23a. Did tobacco usa contributa to the causa of daath? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yas 2☐No

24b. Wara autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was casa referred to medical examinar? 1☒ Yes 2☐ No

28. Place of Death (Check only ona)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Othar: 4☐Nursing Homa 5☐Rasidanca 6☐Othar (Specify)

27. Mannar of Death: 1☐Natural 2☒Accidant 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be determined

28a. Data of Injury (Month, Day Yaar): 2-2-01

28b. Tima of Injury: 9:44 AM

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: subject choked on food

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify): home

28f. Location (Street and Numbar or Rural Routa Numbar, City or Town, Stata): 344 S. Mason Ct., Balto., MD

29a. Certifier (Check only ona): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, dete and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of Certifier:

29c. Licansa number: OCME

29d. Data signed (Month, Day, Yaar): FEBRUARY 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Alan Cooke, MD 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed (Month, Day, Yaar): FEB 07 2001

32. Registrar's Signatura: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03283

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Coleman Smith

2. Date of Death Month: Feb Day: 02 Year: 2001

3. Time of Death: 8:40am

4a. Facility Name *(If not institution, give street and number)*: 1027 Abbott Court

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 243-30-3443

6. Sex: XX 1☐M 2☐F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 03-07-26

9. Birthplace *(State or Foreign Country)*: NC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX 1☐Yes 2☐No

10e. Street and Number: 1027 Abbott Court

10f. Zip Code: 21201

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4XX☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes XX☐No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 3rd. Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Company

17. Father's Name *(First, Middle, Last)*: Austin Smith

18. Mother's Name *(First, Middle, Maiden Surname)*: Arbella Hinton

19a. Informant's Name/Relationship *(Type, Print)*: Walter Smith

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3806 Bowers Avenue Baltimore, MD. 21207

20a. Method of Disposition: XX 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Voshell Mem. Gardens

Date: 02-08-01

20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funeral Service Licensee: Joseph R. Walter Jr

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arrhythmia (Probable) — 10 minutes

Due to (or as a consequence of):

b. Coronary Artery Disease — 13 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hyperlipidemia, Diabetes

23b. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death *(Check only one)*

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☑Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D0052104

29d. Date signed *(Month, Day, Year)*: February 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy Loo, 1000 E. Eager St., Baltimore MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 07 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03284

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: WARREN J. STANLEY

2. Dete of Deeth — Month: Febuary Dey: 5 Year: 2001

3. Time of Death: 12:38 Am

4e. Facility Neme *(If not institution, give street and number)*: Union Memorial

4b. City, Town, or Location of Death: Balto

4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 212-40-2498

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 55 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Year)*: 01-11-46

9. Birthplece *(Stete or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1008 DARLEY AVENUE

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐Never Married 2☒Merried 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Rece - American Indian, Bleck, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: CONTRACTOR

16b. Kind of Business/Industry: HOME IMPROVEMENT

17. Father's Neme *(First, Middle, Last)*: STERLING A. STANLEY

18. Mother's Neme *(First, Middle, Meiden Surname)*: FLORENCE COOPER

19a. Informent's Neme/Reletionship *(Type, Print)*: FRANCES FRISBY/DEPENDENT FRIEND

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1008 DARLEY AVENUE, BALTIMORE, MD 21218

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other plece)*: KING MEMORIAL PK.

Dete: 2/8/2001

20c. Location - City or Town, State: BALTO., MD.

21. Signeture of Funerel Service Licensee: James A. Morton

22. Neme end Address of Fecility: JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD. 21217

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interel Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in deeth)

a. Cardiopulmonary Arrest — 6 hours

Due to (or as e consequence of):

b. Hepatic encephalopathy, Liver Failure — 16 hours

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of):

c. Advanced liver disease with Cirrhosis — 3 years

Due to (or es e consequence of):

d. Renal failure — 2 years

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Hepatitis C, Alcoholic liver disease Coagulopathy.

23b. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐Yes 2☒No

25. Wes case referred to medical exeminer? 1☐Yes 2☒No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☒Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner es stated. 2☐**Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Chun Hong MD PhD.

29c. License number: AT 243 8946

29d. Dete signed *(Month, Dey, Yeer)*: Febuary 5, 2001

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Chun Hong, Union Memorial Hospital, 201 E Univ Pkwy Baltimore, MD 21218

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: FEB 07 2001

32. Registrer's Signeture: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4/675

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03285

Physician /Medical Examiner

1. Decedent's Nama *(First, Middla, Last)*: Clyde Thames Jr.

2. Date of Death (Month, Day, Year): Jan. 29, 2001

3. Tima of Death: 9:pm

4a Facility Name *(If not institution, give street and number)*: 7906 Rosaryville Road

4b. City, Town, or Location of Death: Upper Marlboro

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 424-30-4725

6. Sex: 1☒M 2☐F

7. Aga *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: Aug.12,1926

9. Birthplaca *(Stata or Foreign Country)*: Alabama

Usual Rasidence of Decadant

10a. Stata: Md.

10b. County: Prince Georges

10c. City, Town or Location: Upper Marlboro

10d. Insida City Limits: 1☒Yaa 2☐No

10e. Street and Number: 7906 Rosaryville Road

10f. Zip Coda: 20772

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐Navar Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, apecify Cuban, Mexican, Puarto Rican, atc.) 1☐Yas 2☒No *Specify:*

14. Race - Amarican Indian, Black, Whita, etc. *Specify:* Black

15. Decadant's Educetion *(Specify only highast grada completad)*: Elamantary/Secondary (0-12): 11 / Collega (1-4or 5+)

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Maintenance Worker

16b. Kind of Businass/Industry: Safeway Foods

17. Father's Nama *(First, Middla, Last)*: Clyde Thames Sr.

18. Mothar's Nama *(First, Middle, Maiden Surname)*: Essie Kelly

19a. Informant's Name/Ralationship *(Type, Print)*: Michelle Melton Daughter

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 7906 Rosaryville Rd.Upper Marlboro,Md.

20a. Mathod of Disposition: 1☒Buriel 2☐Cramation 3☐Ramoval from State 4☐Donation 5☐Other *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Resurrection Cem.

Data: 2/3/01

20c. Location - City or Town, State: Clinton,Md.

21. Signature of Funaral Sarvica Licansaa: Francis B. Hunt

22. Nama and Addrasa of Facility: Hunt Funeral Home 908 Kennedy St.N.W.Wash.D.C.20011

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only ona cause on each line.

Approximata Interval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in daath)

a. Colon Cancer

Dua to (or as a consequanca of):

Sequentially list conditiona, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or Injury that initiatad avants rasulting in death) Last

b.

Dua to (or as a consequanca of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa given in Part I.

23b. Did tobacco usa contributa to the causa of death? 1☐Yas 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Were autopsy findings available prior to completion of causa of death? 1☐Yas 2☐No

25. Was casa rafarrad to medical examiner? 1☐Yas 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA Othar: 4☐Nursing Homa 5☒Rasidanca 6☐Othar *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending invastigation 6☐Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurrad

28e. Placa of Injury - At homa, farm, strast, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒**Cartifying Physician**: To tha bast of my knowladga, death occurrad at tha tima, data and placa, and dua to tha causa(s) and manner as stated. 2☐**Madical Examinar**: On the basis of examination and/or invastigation, in my opinion, death occurrad at tha tima, data and placa, and due to tha cause(s) and mannar stated.

29b. Signature and titia of cartifiar: Daryl Hill

29c. License number: 0053235

29d. Date signed *(Month, Day, Yaar)*: 1/31/01

30. Nama and addrass of parson who complatad causa of death (Item 23a) (Type, Print): Darryl Hill, M.D. 6104 Old Branch Ave. Temple Hills,Md.

State Registrar

31. Data filad *(Month, Day, Yaar)*: FEB 07 2001

32. Registrar's Signatura: Brenda G. Sparks

DHMH 16 Rav 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 03286

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Mildred Whittington			February 5 2001	11:30 AM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
University of Maryland Medical Center	Baltimore, MD		N/A	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-20-8874	1☐ M 2☑ F	76 Yrs.			MAY 16, 1924	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE	1☑ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3931 Edmondson Avenue	21229	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced	1☐ Yes 2☑ No If Yes, Give Year or Dates:	1☐ Yes 2☑ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		DOMESTIC	PRIVATE FAMILIES

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ARCHIE REID	ANNIE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
IRVIN Whittington, JR./SON	2501 HARLEM Ave. Balto. MD 21216

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BALTO. NATIONAL	2/9/2001	BALTO. MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Blenda Edens Jones	MARSHALL W. JONES, SR. I-H PA 4101 Edmondson Ave. Balto. MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. End stage Renal disease	1 year
	c. Hypertension	20 years
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☑ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Mikael Poocas MD	Res000	Feb 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
22 S. Greene St. Baltimore, MD 21201, Mikael Poocass

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 07 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03287

West, James

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES WEST

2. Date of Death: Month Jan. Day 29 Year 2001

3. Time of Death: 9:20 a.m.

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 260 22 4494

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2/28/1919

9. Birthplace (State or Foreign Country): GEORGIA

Usual Residence of Decedent

10a. State: MD.

10b. County: A.A. CO.

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 7361 HOLSTEIN AVE.

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes [X] No Specify:

14. Race - American Indian, Black, White, etc. AFRO Specify: AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FORK LIFT OPERATOR

16b. Kind of Business/Industry: DUPONT CO.

17. Father's Name (First, Middle, Last): LUKE WEST

18. Mother's Name (First, Middle, Maiden Surname): IDA WEST

19a. Informant's Name/Relationship (Type, Print): GERTRUDE WEST WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7361 HOLSTEIN AVE. GLEN BURNIE, MD 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CEDAR HILL Date: 02/2/01

20c. Location - City or Town, State: BROOKLYN, MD.

21. Signature of Funeral Service Licensee: CECIL A. ESTEP Cecil A. Estep

22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFRACTION — 1 HR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — 20 YRS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Shavers, M.D.

29c. License number: D27838

29d. Date signed (Month, Day, Year): 1/30/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN SHAVERS, 518 CAMP MEADE ROAD, LINTHICUM, MD 21090

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03288

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BETTY WALLACE
2. Date of Death: Month 2 Day 4 Year 01
3. Time of Death: 4:23 pm
4a. Facility Name (If not institution, give street and number): Bon Secours Hosp
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 216-58-0334
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-4-32
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD.
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1516 ELLAMONT ST
10f. Zip Code: 21216
10g. Citizen of What Country? USA.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): JACK BUTLER
18. Mother's Name (First, Middle, Maiden Surname): MILDERD MONQUER

19a. Informant's Name/Relationship (Type, Print): LEROY WALLACE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3711 BARRINGTON AVE. BALTO. MD. 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALTO. NATIONAL CEM.
Date: 2/9/01
20c. Location - City or Town, State: BALTIMORE MD.

21. Signature of Funeral Service Licensee: ▶ Cecil C. Estep
22. Name and Address of Facility: ESTEP BROTHERS FH.P.A. 1300 EUTAW PLACE BALTIMORE MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE

Due to (or as a consequence of):
b. CARDIAC ARREST

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CANCER lung

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A. Miller
29c. License number: 21348
29d. Date signed (Month, Day, Year): 02-04-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AJAIB S. SIDHU. MD. 1510 W. MOUNT ST. BALTO 21217

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: ▶ Barbara G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03289

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELWOOD CHARLES WHITELY

2. Date of Death (Month, Day, Year): February 5 2001

3. Time of Death: 5:06 P.M

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213-20-4692

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 08 1917

9. Birthplace *(State or Foreign Country)*: Penna.

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1510 Plum Street

10f. Zip Code: 21226

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Firefighter

16b. Kind of Business/Industry: Baltimore City

17. Father's Name *(First, Middle, Last)*: Charles Whitely

18. Mother's Name *(First, Middle, Maiden Surname)*: Greta Lary

19a. Informant's Name/Relationship *(Type, Print)*: Laurel Wanless (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1343 Ashburton Drive, Millersville, Md. 21108

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cemetery

Date: 2/08/2001

20c. Location - City or Town, State: Crownsville, Md.

21. Signature of Funeral Service Licensee: George M. Hampton Jr.

22. Name and Address of Facility: McCully-Polyniak Funeral home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D43977

29d. Date signed *(Month, Day, Year)*: February 5 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Angelos Dimitriou - 301 Hospital Drive, Glen Burnie MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 07 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ELWOOD WHITELY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03290

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael Allen Weiland
2. Data of Death — Month: 2 Day: 4 Year: 01
3. Time of Death: 11:33 AM
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219-25-5652
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 12 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): March 28 1988
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel Co.
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 317 Green Drive
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, atc. Specify: white

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 7 — Cottega (1-4or 5+): 0
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): student
16b. Kind of Business/Industry: n/a

17. Fathar's Nama (First, Middla, Last): Carl Henry Weiland III
18. Mother's Name (First, Middle, Maiden Surnama): Tammy Ratcliff

19a. Informant's Name/Relationship (Type, Print): Carl H. Weiland III (Father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 317 Green Drive, Pasadena, Md. 21122

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or other place): Glen Haven Memorial Park
Data: 2/08/2001
20c. Location - City or Town, Stata: Glen Burnie, Md.

21. Signature of Funeral Service Licensee: George M. Hampton Jr.
22. Nama and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona cause on aach lina. — Approximata Intarval Batween Onset and Death

Immediata Causa (Finat disaasa or condition rasulting in death):
a. Asystole - Arrhythmia
Dua to (or as a consequence of):
b. Subendocardial Ischemia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disaase or injury that initiated events rasulting in death) Last
c. Severe Hypertrophic Cardiomyopathy
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco usa contribute to the causa of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Ware autopsy findings available prior to complation of cause of death? 1 [ ] Yas 2 [X] No

25. Was casa rafarrad to medical examinar? 1 [X] Yas 2 [ ] No
26. Placa of Death (Check only one): Hospital: 1 [ ] Inpatiant 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurrad at the tima, date and placa, and due to tha causa(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D0020656
29d. Date signed (Month, Day, Year): 2-4-01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): 600 North Wolfe Street, Baltimore, Md 21287

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03291

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHNNY WILSON

2. Date of Death (Month, Day, Year): FEBRUARY 1, 2001

3. Time of Death: 10:55pm

4a. Facility Name (If not institution, give street and number): HARFORD GARDENS NURSING CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

Funeral Director

5. Social Security Number: 220-20-1877

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 13, 1926

9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 4700 HARFORD ROAD

10f. Zip Code: 21214

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): unk

College (1-4or 5+): unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk

18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): ALICE BELLAMY (GUARDIAN)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1000 CATHEDRAL STREET BALTIMORE, MD 21201

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY

Date: 2/6/01

20c. Location - City or Town, State: LANSDOWNE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: WYLIE FUNERAL HOME PA
638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tasneem Lakhani

29c. License number: D28595

29d. Date signed (Month, Day, Year): 2/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE, BALTIMD 21208

State Registrar

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: Bernice D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03292

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Desiree Alvarez
2. Date of Death: Month January Day 16 Year 2001
3. Time of Death: 2:57 AM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 261-57-5853
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 41 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 3, 1959
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits? 1☒ Yes 2☐ No
10e. Street and Number: 103 East 6th Street
10f. Zip Code: 21701
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No Specify: Spanish
14. Race - American Indian, Bieck, White, etc. Specify: Hispanic
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12); College (1-4or 5+): 2
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home
17. Father's Neme (First, Middle, Last): Robert Carl Alvarez
18. Mother's Neme (First, Middle, Meiden Surneme): Margaret Padilla
19a. Informent's Neme/Reletionship (Type, Print): Dax F. Alvarez (Brother)
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 18603 Walkers Choice Rd. #2-Mont. Village, MD 20886
20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca): Metropolitan Crematory
Date: 1/17/01
20c. Location - City or Town, State: Alexandria, Virginia
21. Signeture of Funerel Service Licensee: Robert J. DeVol
22. Name and Address of Feciliity: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Final diseese or condition resulting in death)
a. Upper gastrointestinal bleeding — 12 hrs
Due to (or es e consequence of):
b. Gastric Varices — 1 year
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
Due to (or es a consequenca of):
c. Laennecs cirrhosis — 5 years
Due to (or es a consequenca of):
d. Alcoholism — 20 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end placa, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner steted.
29b. Signeture end title of certifier: William A Mirka, MD
29c. License number: D142373
29d. Date signed (Month, Day, Year): 1/16/2001
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): William A Mirka, MD 804 Tri-Hosp Dr Frederick, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signeture: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 03293

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NATALIE L. ADAMS

2. Date of Death (Month, Day, Year): January 24, 2001

3. Time of Death: 8:38 A.M.

4a. Facility Name (If not institution, give street and number): 5508 Duke Court

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-52-1015

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 51 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 23, 1949

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5508 Duke Court

10f. Zip Code: 21703

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: National Inst. of Health

17. Father's Name (First, Middle, Last): Milton U. Randolph

18. Mother's Name (First, Middle, Maiden Surname): Edwina V. Lee

19a. Informant's Name/Relationship (Type, Print): Janise W. Hill / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5508 Duke Court / Frederick, Maryland 21703

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hopehill Cemetery

Date: 01-29-01

20c. Location - City or Town, State: Hopeland, Maryland

21. Signature of Funeral Service Licensee: Raymond Peterson

22. Name and Address of Facility: Stauffer Funeral Home, 1621 Opossumtown Pike/ Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. BRAIN METASTASES — 4 MONTHS

Due to (or as a consequence of):

b. ADENOCARCINOMA OF THE BREAST — 5 1/2 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Brian M O'Connor, M.D

29c. License number: D31761

29d. Date signed (Month, Day, Year): 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN M. O'CONNOR MD 581 W. SEVENTH ST. FREDERICK, MD 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03294

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GHULAM ALI

2. Date of Death (Month, Day, Year): Jan 24th, 2001

3. Time of Death: 7:30pm

4a. Facility Name *(If not institution, give street and number)*: SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 602-38-7699

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 1, 1948

9. Birthplace *(State or Foreign Country)*: Pakistan

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Wheaton

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 11927 Veirs Mill Rd #302

10f. Zip Code: 20906

10g. Citizen of What Country?: Pakistan

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Taxi Driver

16b. Kind of Business/Industry: Taxi

17. Father's Name *(First, Middle, Last)*: Mohammad Khan

18. Mother's Name *(First, Middle, Maiden Surname)*: Unavailable

19a. Informant's Name/Relationship *(Type, Print)*: Shaukat M. Malik-Friend

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12 Lawngate Ct, Potomac, Md. 20894

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Family Cemetery

Date: 1-29-2001

20c. Location - City or Town, State: Islamabad Pakistan

21. Signature of Funeral Service Licensee: Paul de Mata

22. Name and Address of Facility: Universal II Mortuary Inc. 411 Kennedy St, N.W., Washington, D.C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

b. HYPOTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. RESPIRATORY FAILURE

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: H51280

29d. Date signed *(Month, Day, Year)*: 1-24-2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dadgar Anushiravan, MD 13219 Executive Pk. Terr, Germantown, Md. 20874

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: Bernice G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ghulam, Ali, 1-24-01, 7:03PM GF

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03295

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Peter Arthur Alsberg

2. Date of Death — Month: JAN. Day: 24 Year: 2001

3. Time of Death: 9:42 AM

4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 152-48-4399

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 41 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Aug 16, 1959

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Takoma Park

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 32 Columbia Avenue

10f. Zip Code: 20912

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Art Director

16b. Kind of Business/Industry: Washington Post

17. Father's Name *(First, Middle, Last)*: Harold Alsberg

18. Mother's Name *(First, Middle, Meiden Sumame)*: Hilde Weil

19a. Informent's Name/Relationship *(Type, Print)*: Janis Stovall / Wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 32 Columbia Avenue, Takoma Park, MD 20912

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Metropolitan Crematory

Date: Jan 26 2001

20c. Location - City or Town, Stete: Alexandria, VA

21. Signature of Funeral Service Licensee: Andrew J. Cole

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd, W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line.

Approximate Interval Between Onsat and Deth

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Colon Cancer

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Dua to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatiant 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: James K Lightfoot Jr, M.D

29c. License number: 52326

29d. Date signed *(Month, Dey, Year)*: 1/24/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): James K Lightfoot Jr MD Washington Adventist Hospital

State Registrar

31. Data filed *(Month, Dey, Year)*: JAN 26 2001

32. Registrar's Signatura: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03296

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARLENE ARONSON
2. Date of Death (Month, Day, Year): JANUARY 22, 2001
3. Time of Death: 3:50 P.M.
4a. Facility Name *(If not institution, give street and number)*: 5801 NICHOLSON LANE, # 1720
4b. City, Town, or Location of Death: N. BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 123-24-6704
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEB. 5, 1934
9. Birthplace *(State or Foreign Country)*: NEW HAMPSHIRE

Usual Residence of Decedent

10a. State: NEW YORK
10b. County: SARATOGA
10c. City, Town or Location: SARATOGA SPRINGS
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9 RITCHIE COURT
10f. Zip Code: 12866
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 YEARS — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME
17. Father's Name *(First, Middle, Last)*: DAVID SKLUTE
18. Mother's Name *(First, Middle, Maiden Surname)*: LENA WEXLER
19a. Informant's Name/Relationship *(Type, Print)*: NOLAN SKLUTE - BROTHER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5801 NICHOLSON LANE, # 1720 N. BETHESDA, MARYLAND 20852
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SHAARA TIFILLE CEMETERY
Date: 1/23/2001
20c. Location - City or Town, State: SARATOGA SPRINGS, N.Y.
21. Signature of Funeral Service Licensee: Donald C. Stottlemyer
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. LUNG CANCER	6 MONTHS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* BRO'S RES.

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kennett Goldstein
29c. License number: D0017211
29d. Date signed *(Month, Day, Year)*: JANUARY 22. 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth Goldstein, M.D. 2141 K. STREET, N. W., WASHINGTON, D. C.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001
32. Registrar's Signature: Bruce B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03297

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Peter J. Boyle

2. Date of Death Month Day Year: January 24, 2001

3. Time of Death: 4:32 am

4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-38-9891

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 27, 1916

9. Birthplace *(State or Foreign Country)*: Minnesota

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 14713 Jaystone Drive

10f. Zip Code: 20905

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Director of Safety

16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: Leo C. Boyle

18. Mother's Name *(First, Middle, Maiden Surname)*: Ida Mettling

19a. Informant's Name/Relationship *(Type, Print)*: Katherine Diane Boyle/ Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14713 Jaystone Drive, Silver Spring, MD 20905

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: Jan 27 2001

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: James E. Dodge

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Respiratory Acidosis — 24 hours

Due to (or as a consequence of):
b. Cerebrovascular Accident — 24 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Peripheral Vascular disease

Congestive Heart failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alok Mathur Physician

29c. License number: D0055694

29d. Date signed *(Month, Day, Year)*: January 24, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Alock Mathur, MD 4000 Olney-Laytonsville Road, Olney, MD 20832

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signature: Jeanne B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#23a per MD FCHD,ks **Certificate of Death** 01/31/01 Reg. No: 2001 03298

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Russell James Baker
2. Date of Death Month Jan. Day 21, Year 2001:
3. Time of Death: 11:05 AM
4a. Facility Name (If not institution, give street and number): 3938 Brethren Church Rd.
4b. City, Town, or Location of Death: Myersville
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 217-16-2488
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 5, 1923
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: Frederick
10c. City, Town or Location: Myersville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 3938 Brethren Church Rd.
10f. Zip Code: 21773
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): sexton
16b. Kind of Business/Industry: church

17. Father's Name (First, Middle, Last): James E. Baker
18. Mother's Neme (First, Middle, Maiden Surname): Etta Mae Summers

19a. Informant's Name/Relationship (Type, Print): Naomi S. Baker (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3938 Brethren Church Rd., Myersville, MD. 21773

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Lutheran Cemetery
Data: 1/24
20c. Location - City or Town, State: Middletown, MD.

21. Signature of Funeral Service Licensee: Mike S Thoffs
22. Name and Address of Facility: Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach lina.

Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death)
a. Prostate Cancer — 6 Y

Dua to (or as a consequence of):
b. — 6 Y

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lsst
Due to (or as e consequence of):
c.
Due to (or as s consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Wes en autopsy performed? 1☐Yes 2☑No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case rafarred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Panding investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician**: To the best of my knowledga, death occurred at the tima, data and place, and due to tha cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, snd dua to the cause(s) and manner stated.

29b. Signature and title of certifier: W Hander MD
29c. License number: D48184
29d. Data signed (Month, Day, Year): 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elhamy ESKander, MD 501 W 7th Street Frederick, MD 21701

State Registrar

31. Data filed (Month, Day, Year): JAN 2 9 2001
32. Registrar's Signeture: Benna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03299

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry J. Bogin

2. Date of Death (Month, Day, Year): January 16, 2001

3. Time of Death: 2:50 AM

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 064-18-5885

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 25, 1920

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Florida

10b. County: Broward

10c. City, Town or Location: Pompano Beach

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4020 Palm Aire Drive West

10f. Zip Code: 33069

10g. Citizen of What Country?: United States

11. Meritel Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner

16b. Kind of Business/Industry: Construction Company

17. Father's Name (First, Middle, Last): Chaim Bogin

18. Mother's Name (First, Middle, Maiden Surname): Sarah Carlin

19a. Informant's Name/Relationship (Type, Print): Matthew B. Bogin/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6304 Friendship Court, Bethesda, Maryland 20817

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Beth El Cemetery | Date: Jan. 18 2001

20c. Location - City or Town, State: Harrisburg, PA

21. Signature of Funeral Service Licensee: David Levy M00803

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory srrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE GASTROINTESTINAL BLEEDING

Due to (or as a consequence of):
b. ABDOMINAL AORTIC ANEURYSM

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):
c. CHRONIC RENAL FAILURE

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yee 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings svsilable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was casa referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture snd title of certifier: Alpana Goswami M.D.

29c. License number: D-27660

29d. Date signed (Month, Day, Year): 1/16/01

30. Name end address of parson who completed cause of death (Item 23a) (Type, Print): ALPANA GOSWAMI M.D. 10901 CONNETICUT AVE, KENSINGTON MD 20895

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Renee B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

01/16/2001 2:50 Am. BOGIN, HENRY

25 T1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03300

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joan Fralick Bartlett
2. Date of Death Month / Day / Year: January 16, 2001
3. Time of Death: 7:00 PM
4a. Facility Name *(If not institution, give street and number)*: Montgomery Village Care & Rehabilitation Cntr.
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 149-22-4588
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 7,1927
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: New Market
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6598 Waters Edge Court
10f. Zip Code: 21774
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: George Fralick
18. Mother's Neme *(First, Middle, Maiden Surname)*: Gertrude McBride

19e. Informant's Name/Relationship *(Type, Print)*: Keith Bartlett (son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6598 Waters Edge Court - New Market, MD. 21774

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Dete: 1/17/01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Michael Bullock
22. Name end Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive - Gaithersburg, MD.20877

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Causa (Finai disease or condition resulting in deeth)
a. myocardial infarction — Due to (or es a consequence of): — Immediate
b. insulin dependent diabetes mellitus — Due to (or as a consequence of):

Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting In death) Last
c. — Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: deforming rheumatoid arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Steven Dolinsky
29c. License number: 20148
29d. Date signed *(Month, Day, Year)*: January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Dolinsky MD 911 Russel Ave, Gaithersburg Md.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: Bonnie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03301

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PETER JOHN BELASCO

2. Date of Death Month Day Year: JANUARY 16, 2001

3. Time of Death: 11:00 A.M.

4a. Facility Name *(If not institution, give street and number)*: 19228 DEEP RUN COURT

4b. City, Town, or Location of Death: GERMANTOWN

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 132-48-4687

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 45 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 7, 1955

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 19228 Deep Run Court

10f. Zip Code: 20876

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12); College (1-4or 5+): 2

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Technician

16b. Kind of Business/Industry: Computer

17. Father's Neme *(First, Middle, Last)*: George Anthony Belasco

18. Mother's Name *(First, Middle, Meiden Surneme)*: Mary Catherine Shovlin

19a. Intormant's Neme/Reletionship *(Type, Print)*: Daniel Belasco/Brother

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 8 White Birch Lane, Sparta, New Jersey 07871

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Metropolitan Crematory

Date: 1/20/01

20c. Location - City or Town, Steta: Alexandria, Virginia

21. Signeture of Funerel Service Licensee: Michael A Luebbers

22. Neme and Address of Facility: DEVOL FUNERAL HOME 10 E. DEER PARK DRIVE, GAITHERSBURG, MD 20877

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart tailure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Rectal Cancer — 6 Years

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b.

Due to (or es e consequence ot):

c.

Due to (or es a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion ot cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: Joseph Haggerty MD

29c. License number: D32407

29d. Date signed *(Month, Day, Year)*: JANUARY 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH A. HAGGERTY, M.D., 9707 MEDICAL CENTER DRIVE, #300 ROCKVILLE, MD 20850

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 19 2001

32. Registrar's Signetura: Bonnie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03302

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELSIE ELIZABETH BLANK

2. Date of Death — Month: JANUARY Day: 19, Year: 2001

3. Time of Death: 1:12 AM

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-14-2423

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Jan. 5, 1923

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Myersville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2507 Monument Road

10f. Zip Code: 21773

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembler

16b. Kind of Business/Industry: Optical Company

17. Father's Name *(First, Middle, Last)*: Frederick Tyeryar

18. Mother's Name *(First, Middle, Maiden Surname)*: Elsie Shelton

19a. Informant's Name/Relationship *(Type, Print)*: William F. Blank, Jr./Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2507 Mounment Road, Myersville, Maryland 21773

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery

Date: Jan. 22, 2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Richard C. C. Basford MD0021

22. Name and Address of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebral infarction, massive — 5 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Diabetes mellitus, II — 10-15 yrs

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert S. Hughes, MD

29c. License number: D0511

29d. Date signed *(Month, Day, Year)*: 1/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert S. Hughes, M.D., 700 Montclair Ave., Frederick, Md. 21701

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: ▶ Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03303

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Claire G. Bochicchio
2. Date of Death: Month January Day 17 Year 2001
3. Time of Death: 11:20 PM
4a. Facility Name (If not institution, give street and number): 11413 Farmland Drive
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 091-12-5451
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 29, 1913
9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11413 Farmland Drive
10f. Zip Code: 20852
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+): –
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Leonard Parkin
18. Mother's Name (First, Middle, Maiden Surname): Clara Gilbert

19a. Informent's Name/Relationship (Type, Print): Anthony J. Bochicchio/ Husband
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11413 Farmland Drive, Rockville, Maryland 20852

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Plece of Disposition (Name of cemetery, crematory or other placa): Arlington National Cemetery
Date: January 23, 2001
20c. Location - City or Town, Stete: Arlington, Virginia

21. Signeture of Funerel Service Licensee: ▶ [signature] #00689
22. Neme and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death): a. Breast Cancer — 8 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or es a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: ▶ [signature] MD
29c. License number: D21981
29d. Dete signed (Month, Day, Year): January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lloyd Ketchum, M.D. 8901 Wisconsin Avenue, Third Floor, Bethesda, MD 20889-5000

State Registrar

31. Dete filed (Month, Day, Year): JAN 22 2001
32. Registrer's Signeture: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03304

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONALD Dixon BIRCHWOOD
2. Date of Death: Month JANUARY Day 12 Year 2001
3. Time of Death: 11:15
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

Funeral Director

5. Social Security Number: 267-34-6284
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 70 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 3, 1930
9. Birthplace (State or Foreign Country): Jacksonville, FL

Usual Residence of Decedent

10a. State: WV
10b. County: Hampshire
10c. City, Town or Location: Capon Bridge
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: HC 61 Box 69J
10f. Zip Code: 26711
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Consumer Service Representive
16b. Kind of Business/Industry: Whirlpool Corp.

17. Father's Name (First, Middle, Last): Charles B. Birchwood
18. Mother's Name (First, Middle, Maiden Surname): Billie Dixon

19a. Informant's Name/Relationship (Type, Print): Laura Birchwood - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): HC61, Box 69J, Capon Bridge, WV 26711

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): Capon Chapel Cemetery
Date: 1/16/01
20c. Location - City or Town, State: Capon Bridge, WV

21. Signature of Funeral Service Licensee: Dennis G. [illegible]
22. Name and Address of Facility: Griffin Funeral Home, Capon Bridge, WV 26711

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ASCENDING AORTIC ANEURYSM — 2 DAYS
Due to (or as a consequence of):
b. HYPERTENSION — 20 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: RES-000
29d. Date signed (Month, Day, Year): JANUARY 12 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL G. HOUSE, M.D. THE JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST.

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0215-031
B.K.S
KATHERINE BENNETT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITMES#23a,ptII& 27 per ME G793 030601 SS *Certificate of Death*

Reg. No. 2001 03305

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Katherine Elizabeth Bennett
2. Date of Death Month Day Year: JAN. 13, 2001
3. Time of Death: 0936 AM
4a. Facility Name *(If not institution, give street and number)*: 13442 RISING SUN LANE
4b. City, Town, or Location of Death: GERMANTOWN
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-60-6805
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 55 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 9, 1945
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13442 Rising Sun Lane
10f. Zip Code: 20874
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): – ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Junior High School

17. Father's Name *(First, Middle, Last)*: Raymond Charles Winchester
18. Mother's Name *(First, Middle, Maiden Surname)*: Sara King

19a. Interment's Name/Relationship *(Type, Print)*: Harriet Page/ Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1 Cloverhill Drive, Stafford, Virginia 22554

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery
Date: January 19, 2001
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. SEIZURE DISORDER ASSOCIATED WITH ANTIPSYCHOTIC THERAPY
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SCHIZOPHRENIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* AT SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.D.
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: JAN. 14, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: Donna G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03306

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frederick Ernest Beck
2. Date of Death (Month, Day, Year): January 23, 2001
3. Time of Death: 2:30am
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 056-05-5851
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 31, 1915
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 211 Russell Ave. #214
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 41-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Importer
16b. Kind of Business/Industry: Fiber Industry

17. Father's Name (First, Middle, Last): Ernest Charles Beck
18. Mother's Name (First, Middle, Maiden Surname): Margaret Kronan

19a. Informant's Name/Relationship (Type, Print): Douglas Beck /Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7828 Hidden Meadow Terrace, Potomac, MD 20854

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory | Date: Jan 26 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Beverly L Hewlett
22. Name and Address of Facility: Rapp Funeral Home & Cremation Services 933 Gist Ave. Silver Spring, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	24 Hours
Due to (or as a consequence of): b.	Acute Respiratory Failure	24 Hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	End-Stage Renal Disease	
Due to (or as a consequence of): d.	Hypertension	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus; Dementia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: VinuGanti
29c. License number: D41162 MD
29d. Date signed (Month, Day, Year): January 23 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): V Ganti MD 19529 Doctor Drive Germantown MD 20874

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

30+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03307

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George R. Barse, Jr.
2. Date of Death Month / Day / Year: January 21, 2001
3. Time of Death: 1:30 P.M.

4a. Facility Name *(If not institution, give street and number)*: 7005 Wolftree Lane
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-54-9785
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 52 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 28, 1948
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10805 Drumm Avenue
10f. Zip Code: 20895
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; Collega (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Composer
16b. Kind of Business/Industry: Music

17. Fathar's Name *(First, Middle, Last)*: George R. Barse, Sr.
18. Mother's Nama *(First, Middle, Maiden Sumeme)*: Miriam E. Long

19a. Informant's Name/Relationship *(Type, Print)*: Thomas M. Barse-Brother
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 26004 Frederick Rd, Clarksburg, MD 20871

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Montgomery Crematorium, Inc.
Date: January 23,2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature] M00335
22. Name and Addrass of Facility: Robert A. Pumphrey Funeral Home-Rockville, Inc. 300 West Montgomery Ave. Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease or complicetions that caused tha death. Do not entar tha mode of dying, such as cardiac or raspiretory arrest, shock, or heert failure. List only one cause on eech line.

		Approximate Interval Between Onsat and Death
Immediate Ceuse (Finel disaase or condition resulting in deeth) e.	Metastatic Carcinoma of Pancreas	6 months
Due to (or as a consequence of):		
Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or es e consequenca of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco uas contribute to the cause of death?** 1 [ ] **Yss** 2 [X] **No** 3 [ ] **Probably** 4 [ ] **Unknown**

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examinar? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Brother's Residence

27. Menner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ William H. Silverman MD
29c. License number: D27985
29d. Date signed *(Month, Day, Year)*: January 22, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): William H. Silverman, MD 809 Viers Mill Rd., Suite 101, Rockville, MD 20851

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signatura: [signature] G. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03308

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NELSON BARNHART
2. Date of Death Month / Day / Year: January 18, 2001
3. Time of Death: 11:51 AM
4a. Facility Name *(If not Institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-09-1798
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 1, 1911
9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4514 Jamestown Road
10f. Zip Code: 20816
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4 or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Federal Communications Comm.
16b. Kind of Business/Industry: US Government

17. Father's Name *(First, Middle, Last)*: Earl Barnhart
18. Mother's Name *(First, Middle, Maiden Surname)*: Emmalene Nelson

19a. Informant's Name/Relationship *(Type, Print)*: Julia N. Barnhart (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4514 Jamestown Rd; Bethesda, MD 20816

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: National Crematory
Date: 1/23/01
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: W. Antwon Murray
22. Name and Address of Facility: JOSEPH GAWLER'S SONS, INC. 5130 Wisconsin Ave., NW; Washington, DC 20016

GF

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure
Due to (or as a consequence of):
b. Bilateral Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Parkinsons Disease
Due to (or as a consequence of):
d. Cancer of Prostate.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Thomas V. Bosyns
29c. License number: D47330
29d. Date signed *(Month, Day, Year)*: 1/18/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas Joseph 50 W. Edmonston Dr. Rockville. MD 20852

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Barnhart, Nelson G 1-18-01 @ 1151

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001
32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03309

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosa L. Barbieri

2. Date of Death: Month January Day 16 Year 2001

3. Time of Death: 3:00 am

4a. Facility Name (If not institution, give street and number): Manor Care- Bethesda

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-18-2377

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 22, 1910

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Montgomery | 10c. City, Town or Location: Rockville | 10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 11116 Ardwick Drive | 10f. Zip Code: 20852 | 10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner / Operator

16b. Kind of Business/Industry: Beauty Shop

17. Father's Name (First, Middle, Last): Michele Bozzi

18. Mother's Name (First, Middle, Maiden Surname): Giovanna Briganti

19a. Informant's Name/Relationship (Type, Print): Anna B. Reilly / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11116 Ardwick Drive, Rockville, MD 20852

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery | Date: Jan 19 2001

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: ▶ Robert E Ramsey

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARDIAC ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. SEPSIS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Attan Kasid, M.D., Ph.D

29c. License number: D55054

29d. Date signed (Month, Day, Year): JANUARY 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ATTAN KASID 17519 REDLAND ROAD ROCKVILLE MD

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03310

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ESTHER BAND

2. Date of Death (Month, Day, Year): JANUARY 21, 2001

3. Time of Death: 7:10PM

4a. Facility Name (If not institution, give street and number): LUTHERAN HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 212-52-6454

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 15, 1910

9. Birthplace (State or Foreign Country): LITHUANIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9005 BRADFORD ROAD

10f. Zip Code: 20901

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGER

16b. Kind of Business/Industry: REAL ESTATE

17. Father's Name (First, Middle, Last): JACOB YAFFE

18. Mother's Name (First, Middle, Maiden Surname): CHIA VICHNA GOLDBERG

19a. Informent's Name/Reletionship (Type, Print): DR. BERNARD A. BAND / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9809 GLENOLDEN DRIVE, POTOMAC, MD 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): OHEV SHOLOM TALMUD TORAH CONGREGATION CEMETERY

Date: 01/23/01

20c. Location - City or Town, State: WASHINGTON, DC

21. Signeture of Funeral Service Licensee: Donald C. Stottsmyer

22. Name and Address of Facility: DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feiiure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in deeth)

e. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: MD

29c. License number: D50061

29d. Dete signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): DR. SAMUEL MALLER 9701 VEIRS DRIVE, ROCKVILLE, MARYLAND 20850

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

State Registrar

31. Dete filed (Month, Day, Year): JAN 25 2001

32. Registrer's Signeture: Bruce D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03311

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martha Mary Courtot
2. Date of Death (Month, Day, Year): Jan. 17, 2001
3. Time of Death: 5:30 AM
4a. Facility Name (If not institution, give street and number): Fairland Nursing Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 157-30-8924
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 20 1907
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2101 Fairland Road
10f. Zip Code: 20914
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): School Teacher
16b. Kind of Business/Industry: Education

17. Father's Nama (First, Middle, Last): Andrew Minarick
18. Mother's Nama (First, Middle, Maiden Surname): Johanna Chukta

19a. Informant's Name/Relationship (Type, Print): George Courtot/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda): 1332 4th Street, SW Washington, DC 20024

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory Inc
Date: Jan.20 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Sarvice Licensee: Kevin A. Hoody
22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)
a. Pneumonia — 1 Week
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Rasidence 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: Andrew Kundrat MD
29c. License number: D36716
29d. Date signed (Month, Day, Year): January 18, 2001

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Andrew G. Kundrat, M.D. 8317 Cherry Lane, Laurel, Maryland 20707

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrer's Signeture: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03312

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Pauline R. Curtis

2. Date of Death Month / Day / Year: January 18, 2001

3. Time of Death: 4:17 AM

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 241-40-1956

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 21, 1930

9. Birthplace *(State or Foreign Country)*: N. Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Damascus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 24620 Ridge Road

10f. Zip Code: 20872

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Designer

16b. Kind of Business/Industry: Interiors

17. Father's Name *(First, Middle, Last)*: C. C. Roberts

18. Mother's Name *(First, Middle, Maiden Surname)*: Nancy Parlee Howington

19a. Informant's Name/Relationship *(Type, Print)*: Billy W. Curtis - Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 24620 Ridge Road, Damascus, Maryland 20872

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resthaven Memorial Gardens | Date: 1/22/01

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ Robert L. Williams

22. Name and Address of Facility: Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Ischemic Cardiomyopathy — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lactic Acidosis

Diabetes, Parotiditis

Metabolic Encephalopathy Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael Emmer MD

29c. License number: MD 05120

29d. Date signed *(Month, Day, Year)*: 1/19/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MICHAEL EMMER, M.D. 6316 Democracy Blvd Bethesda 20817.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: ▶ Denise B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03313

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JERRY COOPER

2. Date of Death Month / Day / Year: January 21, 2001

3. Time of Death: 9:40 AM

4a. Facility Name *(If not institution, give street and number)*: Prince Georges Hospital Center

4b. City, Town, or Location of Death: Cheverly, MD

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-54-2706

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 18, 1941

9. Birthplace *(State or Foreign Country)*: Warsaw, N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 7819 Dellwood Dr.

10f. Zip Code: 20706

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1964

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Facilities Management Spec

16b. Kind of Business/Industry: Government HHS

17. Father's Name *(First, Middle, Last)*: Bennie Cooper

18. Mother's Name *(First, Middle, Maiden Surname)*: Bernice Faison Cooper

19a. Informant's Name/Relationship *(Type, Print)*: Alice Cooper / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7819 Dellwood Dr., Lanham, MD 20706

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crownsville Veteran

Date: Jan 26 2001

20c. Location - City or Town, State: Crownsville

21. Signature of Funeral Service Licensee: Bernie D. Vann III

22. Name and Address of Facility: James E. Vann Funeral Home, 4804 Ga. Ave. N. W. Wash., D. C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MYOCARDIAL ISCHEMIA

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D0055220

29d. Date signed *(Month, Day, Year)*: 1/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TERRI MATIN, M.D. 3001 HOSPITAL DRIVE CHEVERLY, MD. 20785

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signature: Laura B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03314

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Maria Constantinescu
2. Date of Death (Month, Day, Year): January 22, 2001
3. Time of Death: 1020am
4a. Facility Name *(If not institution, give street and number)*: Mariner Health of Kensington
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 173-44-9337
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 21, 1908
9. Birthplace *(State or Foreign Country)*: Romania

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3000 McComas Ave.
10f. Zip Code: 20895
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesperson
16b. Kind of Business/Industry: Retail Sales

17. Father's Name *(First, Middle, Last)*: Alphonse Romalo
18. Mother's Name *(First, Middle, Maiden Surname)*: Fred Szeculici

19a. Informant's Name/Relationship *(Type, Print)*: Dana Andrews /Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2724 Vista Del Oro, New Port Beach, CA 92660

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory — Date: Jan 26 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ Beverly L Haltta
22. Name and Address of Facility: Rapp Funeral Home & Cremation Services 933 Gist Ave. Silver Spring, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Acute Pneumonia — 48 hours
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dehydration

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Myron L. Lenkin MD
29c. License number: D06674
29d. Date signed *(Month, Day, Year)*: 1/22/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Myron L Lenkin M.D. 2309 Shorefield Rd., Wheaton, MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001
32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03315

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DELMA - COMPTON
2. Date of Death (Month, Day, Year): JANUARY 20, 2001
3. Time of Death: 14:10 PM
4a. Facility Name *(If not institution, give street and number)*: MONTGOMERY GENERAL HOSPITAL
4b. City, Town, or Location of Death: OLNEY
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 227 28 2113
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MARCH 15, 1926
9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17712 RIDGE DRIVE
10f. Zip Code: 20853
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: IRVIN ROWE
18. Mother's Name *(First, Middle, Maiden Surname)*: MARY ELIZABETH SMITH

19a. Informant's Name/Relationship *(Type, Print)*: CONNIE SUE DORSEY, DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 130 KEVIN DRIVE, NEW OXFORD, PA. 17350

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: LAYTONSVILLE CEMETERY
Date: 1/24/01
20c. Location - City or Town, State: LAYTONSVILLE, MD.

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber
22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 3 weeks
Due to (or as a consequence of):
b. Congestive Heart Failure — 2 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ John Morrissey MD
29c. License number: D0055243
29d. Date signed *(Month, Day, Year)*: January 20, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John Morrissey MD 19111 Prince Philip Drive Olney Maryland

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03316

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ezra Lee Cramer, Sr.

2. Date of Death (Month, Day, Year): January 9, 2001

3. Time of Death: 7:46 PM

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 217-32-5579

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 8, 1906

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10a. Street and Number: 310 Redwood Ave.

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Foreman/ Factory

16b. Kind of Business/Industry: Manufacturing

17. Father's Name *(First, Middle, Last)*: George Washington Cramer

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Zimmerman

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Jean E. Lydard, Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 310 Redwood Ave., Frederick, Maryland 21701

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Olivet Cemetery, Jan.

Date: 13, 2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ Richard E. Ley M00255

22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home, 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Bilateral Aspiration Pneumonia — 14 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Francis E Becker MD

29c. License number: D20495

29d. Date signed *(Month, Day, Year)*: 1/10/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Francis E Becker MD; 300 W. 9th St; Frederick, Md 21701

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 11 2001

32. Registrar's Signature: Donna B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03317

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Olga Katherine Collins
2. Date of Death (Month, Day, Year): January 17, 2001
3. Time of Death: 2:20A.

4a. Facility Name (If not institution, give street and number): 13203 Ingleside Drive
4b. City, Town, or Location of Death: Beltsville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-03-1661
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 10, 1918
9. Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13203 Ingleside Drive
10f. Zip Code: 20705
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Marcello L. Fattorini
18. Mother's Name (First, Middle, Maiden Surname): Ines Catherine Bartolenni

19a. Informent's Name/Relationship (Type, Print): John J. Collins - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10a - 10 g

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery | Date: 1/22/2001
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Cerebrovascular Accident — Weeks
Due to (or as a consequence of):
b. Hypertension
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert F. Musselman MD
29c. License number: D47215
29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert F. Musselman, M.D. 3410 Olandwood Ct., #206 Olney, Maryland 20830

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03318

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leonard I. Cobb

2. Date of Death Month / Day / Year: January 21 2001

3. Time of Death: 9:20 a.m.

4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: ROckville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 477-14-0401

6. Sex: 1☒ M 2☐ F

7. Age *(in yrs. last birthday)*: 77 Yrs. — If Under 1 Yaer: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 6. 1923

9. Birthplace *(State or Foraign Country)*: MN

Usual Residence of Decedant

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Montgomery Village

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 9505 Fern Hollow Way

10f. Zip Coda: 20886

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1☒ Yes 2☐ No — If Yas, Giva Yaar or Detes: 1943-1946

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 5+

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Inspector

16b. Kind of Business/Industry: Office of Inspection/ Enforcement

17. Father's Nama *(First, Middla, Last)*: Donald I. Cobb

18. Mothar's Nama *(First, Middle, Maiden Sumame)*: Bernice Shuemacker

19a. Informant's Name/Ralationship *(Type, Print)*: Lana Catherine Cobb/ Wife

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 9505 Fern Hollow Way, Montgomery Village, MD 20886

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramovel from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Gate of Heaven Cemetery — Data: January 25, 2001

20c. Location - City or Town, State: Silver Spring, MD

21. Signatura of Funarat Sarvice Licensee: ▶ Tracy A. Shuen

22. Nama and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Between Onset and Death

Immediata Causa (Final diseasa or condition resulting in death)

a. Acute Arrythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or Injury that initiated evants resulting in death) Last

b.

Due to (or as a consequance of):

c.

Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ Brett Gamma, M.D.

29c. Licansa number: D51980

29d. Data signed *(Month, Day, Year)*: January 21, 2001

30. Nama and addrass of parson who complatad causa of daath (Item 23e) (Type, Print): Brett Gamma M.D., 9901 Medical Center Drive, Rockville, MD 20850

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03319

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HAROLD AMBROSE CHURCH
2. Date of Death (Month, Day, Year): Jan. 19, 2001
3. Time of Death: 11:00 PM.

4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 025-34-3073
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 25, 1910
9. Birthplace (State or Foreign Country): Brazil

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 4400 East-West Highway, #807
10f. Zip Code: 20814
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreign Service Officer
16b. Kind of Business/Industry: US Dept. of State

17. Father's Name (First, Middle, Last): Harold Ambrose Church
18. Mother's Name (First, Middle, Maiden Surname): May Burnerp

19a. tnforment's Neme/Reletionship (Type, Print): Isabel Montes Church (Wife)
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 4400 East-West Hwy., #807; Bethesda, MD 20814

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): National Crematory
Date: 1-23-01
20c. Location - City or Town, Stete: Falls Church, VA

21. Signeture of Funerel Service Licensee: ▶ Nancy A. Percentie
22. Name end Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimer's Disease — 4 Years

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last

b.

Due to (or es e consequenca of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other signiftcant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of tnjury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Pleca of tnjury - At home, ferm, street, fectory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ Ralph M. Coan MD
29c. License number: D01191
29d. Dete signed (Month, Day, Year): January 21, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Ralph M. Coan, MD. 9618 Culver St. Kensington, Md. 20895

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrer's Signeture: ▶ Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

HAROLD CHURCH

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #17,1/29/2001,BMW,Montg.Co. **Certificate of Death** Reg. No. 2001 03320

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian C. Christofaro
2. Date of Death Month: January Day: 16 Year: 2001
3. Time of Death: 5:25 am
4a. Facility Name (If not institution, give street and number): Montgomery Hospice- Casey House
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-05-0643
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 14, 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Brookeville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 371 Quailhill Drive
10f. Zip Code: 20833
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Elwood Bailey ~~Michael P. Christofaro~~
18. Mother's Name (First, Middle, Maiden Surname): Anna Connors

19a. Informant's Name/Relationship (Type, Print): Michael P. Christofaro/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 371 Quailhill Drive, Brookeville,MD 20833

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: Jan 20 2001
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: John L Chapich FD
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Colon Cancer to Liver — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D 35635
29d. Date signed (Month, Day, Year): January 16, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jospeh Kaplan 18111 Prince Philip Drive, Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03321

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tzu Lian Cheng

2. Date of Death: Month January Day 20 Year 2001

3. Time of Death: 9:45 am

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-51-1358

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 10, 1924

9. Birthplace (State or Foreign Country): China

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7404 Monona Terrace

10f. Zip Code: 20855

10g. Citizen of What Country? China

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Bank

17. Father's Name (First, Middle, Last): Ti Cheng

18. Mother's Name (First, Middle, Maiden Surname): Su Chang

19a. Informant's Name/Relationship (Type, Print): David W. Cheng, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7404 Monona Terrace, Rockville, MD 20855

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: Jan 22, 2001

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia — 1 Week

Due to (or as a consequence of):

b. Cerebrovascular Accident — 3 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carl I. Schoenberger MD

29c. License number: D26540

29d. Date signed (Month, Day, Year): January 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carl I. Schoenberger, M.D., 16220 Frederick Road, Gaithersburg, MD 20877

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03322

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alexander H. Charles
2. Date of Death (Month, Day, Year): January 22, 2001
3. Time of Death: 8:20 AM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-04-5703
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 26, 1914
9. Birthplace (State or Foreign Country): Guyana

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 7051 Carroll Avenue, #702
10f. Zip Code: 20912
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Engineer
16b. Kind of Business/Industry: Mining

17. Father's Name (First, Middle, Last): Martin Charles
18. Mother's Name (First, Middle, Maiden Surname): Dora Henry

19a. Informant's Name/Relationship (Type, Print): Bernice Charles / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7051 Carroll Avenue, #702, Takoma Park, MD 20912

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: 01/26/01
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. INTRACEREBRAL HEMORRHAGE — 48 hrs
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CAROTID ARTERY STENOSIS

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D55771
29d. Date signed (Month, Day, Year): JAN 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. Syed A. Mahmood 7600 Carroll Ave. Takoma Park, MD. 20912

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

GF

35

031

CJ

James W. Carter

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03323

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Walter Carter,111

2. Date of Death — Month: January Day: 07 Year: 2001

3. Time of Death: 10:30 P.M.

4a. Facility Name *(If not institution, give street and number)*: 10619 Montrose Avenue

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-62-8219

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 53 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec.1,1947

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Md.

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Streef and Number: 10619 Montrose Avenue

10f. Zip Code: 20816

10g. Citizen of What Country?: USA

11. Meritei Stefus: 1☒ Never Merriad 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedanf Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedanf of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): — College (1-4or 5+): 4

16a. Decedent's Usuai Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Civil Servant

16b. Kind of Business/Industry: US Government

17. Father's Name *(First, Middle, Last)*: James Walter Carter,Jr.

18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Juliet Carr

19e. Informent's Neme/Reletionship *(Type, Print)*: Robert A. Gazzola/personal rep.

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1400 K St.,NW.,Suite 1010,Washington,DC 20005

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Pleca of Disposition *(Neme of camatery, cremetory or other plece)*: Emmitsburg Memorial Cem.

Deta: Jan. 23, 2001

20c. Location - City or Town, Steta: Emmitsburg, Maryland

21. Signafura of Funaral Service Licensee: James E. DeVol

22. Nema end Addrass of Facility: DeVol Funeral Home 2222 Wisconsin Ave.,NW.,Washington,DC 20007

Physician /Medical Examiner

23a. Part I. Enfer the disaese, or complications that caused the daath. Do not antar tha moda of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximate Intervei Between Onset and Deeth

Immediate Cause (Finel disaese or condition resulting in deeth): a. CONTACT GUNSHOT WOUND OF HEAD

Due to (or es a consequenca of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lasf: b.

Due to (or as a consequence of):

c.

Dua fo (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? PARTIAL 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Othar *(Specify)* Scene

27. Manner of Death: 1☐ Neturel 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 1/7/01 FOUND

28b. Time of Injury FOUND: 2200 PM

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: SUBJECT SHOT SELF

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*: AT HOME

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 10619 MONTROSE AVE, BETHESDA, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the tima, date and placa, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: M.D.

29c. Licensa number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: January 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY C. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dafe filed *(Month, Dey, Year)*: JAN 23 2001

32. Registrer's Signetura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6F

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03324

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grover Cleveland Carico, Jr.

2. Date of Death (Month, Day, Year): January 18, 2001

3. Time of Death: 8:00PM

4a. Facility Name (If not institution, give street and number): 302 West Timonium RD

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 231-16-2217

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 29, 1922

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 302 West Timonium RD

10f. Zip Code: 21093

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Branch Manager

16b. Kind of Business/Industry: Southern States

17. Father's Name (First, Middle, Last): Grover Cleveland Carico, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Blanche Peake

19a. Informant's Name/Relationship (Type, Print): Grover C. Carico, III/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 Madison Mills Ct. Baltimore, MD 21228

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc | Date: 1/20/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Laura C. Hardesty

22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RENAL CELL CARCINOMA — 2YRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE.

CEREBROVASCULAR ACCIDENT.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D36231

29d. Date signed (Month, Day, Year): January 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES A. DICKERSON 6701 NORTH CHARLES ST STE 4105 BALTO MD 21204.

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03325

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SABINA CALERO

2. Date of Death (Month, Day, Year): JAN. 24, 2001

3. Time of Death: 5:45 AM

4a. Facility Name *(If not institution, give street and number)*: WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: TAKOMA PARK

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-52-3198

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT. 27, 1910

9. Birthplace *(State or Foreign Country)*: COLOMBIA

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: TAKOMA PARK

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7525 CARROLL AVE.

10f. Zip Code: 20903

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☒ Yes 2☐ No *Specify:* COLOMBIAN

14. Race - American Indian, Black, White, etc. *Specify:* HISPANIC

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 3 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: COOK

16b. Kind of Business/Industry: PRIVATE HOMES

17. Father's Name *(First, Middle, Last)*: BRABILO MURCIA

18. Mother's Name *(First, Middle, Maiden Surname)*: MARJARITA TORRES

19a. Informant's Name/Reletionship *(Type, Print)*: CHARLES CALERO/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13404 YORKTOWN DR., BOWIE, MD. 20715

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GATE OF HEAVEN CEMETERY | Date: 1/27/01

20c. Location - City or Town, State: SILVER SPRING, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers | M00091

22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., 5801 CLEVELAND AVE. RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heert failure. List only one cause on line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)
a. Exacerbated COPD

Due to (or as a consequence of):
b. Acute Bronchitis.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hiatal hernia, Dementia.
Congestive Heart failure
Khyphoscoliosis.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D51083

29d. Data signed *(Month, Day, Year)*: 01 - 24 - 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YISA YUSSUF 6712 Village Park Drive, Greenbelt MD 20770

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signature: B. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03326

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NICHOLAS CAIME

2. Date of Death (Month, Day, Year): JANUARY 22, 2001

3. Time of Death: 12.32 A.M.

4a. Facility Name (If not institution, give street and number): CASEY HOUSE

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 063-03-4437

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MARCH 12, 1914

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: POTOMAC

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 10505 TYLER TERRACE

10f. Zip Code: 20854

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1941-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Presser

16b. Kind of Business/Industry: LADIES GARMENT INDUSTRY

17. Father's Name (First, Middle, Last): VITO CAIME

18. Mother's Name (First, Middle, Maiden Surname): MARIE PULEO

19a. Informant's Name/Relationship (Type, Print): VICTORIA FUENTES _ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10505 TYLER TERRACE, POTOMAC, MARYLAND 20854

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ST. JOHN'S CEMETERY

Date: 1/27/2001

20c. Location - City or Town, State: QUEENS, NEW YORK

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer

22. Name and Address of Facility: DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC CARCINOMA — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. BLADDER CANCER — 2 YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ANEMIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) HOSPICE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

26d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ E. P. Librem MD

29c. License number: D09470

29d. Date signed (Month, Day, Year): JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EUGENE P. LIBREM M. D. 10400 CONNECTICUT AVENUE, KENSINGTON, MARYLAND 20845

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 03327

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary K. Donovan
2. Date of Death (Month, Day, Year): Jan. 16, 2001
3. Time of Death: 7:30 AM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 233-14-8302
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 14, 1917
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12325 New Hampshire Ave.
10f. Zip Code: 20904
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): — College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary/Administrative aid
16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): James E. Donovan
18. Mother's Name (First, Middle, Maiden Surneme): Mae Luby

19e. Informant's Neme/Relationship (Type, Print): Matthew Kane/Attorney
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7910 Woodmont Ave.,#1210, Bethesda, Md. 20814

20e. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory — Date: Jan. 17, 2001
20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: ▶ James E. DeVol
22. Name and Address of Facility: DeVol Funeral Home, 2222 Wisconsin Ave., NW, Washington, DC 20007

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	Respiratory Failure	3 Days
Due to (or as a consequence of): b.	Pneumonia	3 Days
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last — Due to (or as a consequenca of): c.		
Due to (or as a consequenca of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M Karim MD
29c. License number: D 18895
29d. Date signed (Month, Day, Year): January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOBARAK KARIM, 7610 CARROLL AVE, TAKOMA PARK, MD 20912

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#2 per MD FCHD 1/12/2001 — **Certificate of Death** — KS

Reg. No. 2001 03328

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Geraldine Bier Duffy

2. Date of Death: Month Jan. Day 3, ~~2000~~ Year 2001

3. Time of Death: 8:30 AM

4a. Facility Name (If not institution, give street and number): Northampton Manor Nursing Home

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 278-30-4568

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 23, 1921

9. Birthplace (State or Foreign Country): W. VA.

Usual Residence of Decedent

10a. State: MD.

10b. County: Frederick

10c. City, Town or Location: Middletown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6835 Picnic Woods Rd.

10f. Zip Code: 21769

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): custodian

16b. Kind of Business/Industry: federal gov't.

17. Father's Name (First, Middle, Last): Gerald Imley

18. Mother's Name (First, Middle, Maiden Surname): Mary O'Neal

19a. Informant's Name/Relationship (Type, Print): Michael Duffy (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6835 Picnic Woods Rd., Middletown, MD. 21769

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Boiff Cemetery

Date: 1/8

20c. Location - City or Town, State: St. Mary's , W. VA.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Donald B. Thompson Funeral Home, 31 E. Main St., Middletown, MD. 21769

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Liver failure	2 weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	congestive heart failure	1 yr
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MS Rudman MD

29c. License number: D17106

29d. Date signed (Month, Day, Year): 1-08-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M S Rudman, 300 S. Church St. Middletown MD 21769

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: ▶ Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#26per MD FCHD,KS 1/24/01 — **Certificate of Death** — Reg. No. 2001 03329

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clyde Bolton Detamore
2. Date of Death (Month, Day, Year): January 22, 2001
3. Time of Death: 3:00 AM
4a. Facility Name (If not institution, give street and number): 5840 Shookstown Road
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 234-66-2413
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 31, 1942
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5840 Shookstown Road
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: Unknown
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Crane Operator
16b. Kind of Business/Industry: Crane Service

17. Father's Name (First, Middle, Last): Elliott Detamore
18. Mother's Name (First, Middle, Maiden Surname): Maysel Hall

19a. Informant's Name/Relationship (Type, Print): Sallie K. Delaughter, Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5840 Shookstown Road, Frederick, Md. 21701

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory, Jan. 24,
Date: 2001
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: ▶ Richard E. Bay M00255
22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. EMPHYSEMA — 10 YRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: ~~1 [X] Inpatient~~ 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D47611
29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NEIL WALAWALKAR MD 1475 TANEY AVE #204 FREDERICK MD 21702

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03330

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francis P. DiCesare
2. Date of Death (Month, Day, Year): January 23, 2001
3. Time of Death: 7:55 pm
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 207-05-0528
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 17, 1911
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1412 Ruatan Street
10f. Zip Code: 20783
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1941-1945
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Expiditer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Antonio DiCesare
18. Mother's Neme (First, Middle, Maiden Surname): Concetta DiCesare

19a. Informant's Name/Relationship (Type, Print): Frances G. DiCesare/ Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1412 Ruatan Street, Hyattsville, MD 20783

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Maryland Veteran's Cemetery
Date: Jan 29, 2001
20c. Location - City or Town, Stete: Crownsville, MD

21. Signature of Funeral Service Licensee: ▶ J. Ken Stike
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth

Immediate Cause (Finat disease or condition resulting in death): a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Atrial Fibrillation

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Anasarca

Inguinal Hernia

Benign Prostatic Hypertrophy

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Lynne Diggs MD
29c. License number: D 34472
29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lynne Diggs, MD 1500 Forest Glen Road, Silver Spring, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: ▶ Linda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03331

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD W. DAVIS

2. Date of Death (Month, Day, Year): JANUARY 17, 2001

3. Time of Death: 11:48AM

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-32-2893

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept.12,1919

9. Birthplace (State or Foreign Country): Wash. DC

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 807 Westmore Avenue

10f. Zip Code: 20850

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 43-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self-employed

16b. Kind of Business/Industry: Home Improvements

17. Father's Name (First, Middle, Last): James W. Davis

18. Mother's Name (First, Middle, Maiden Surname): Mary Agnes Adams

19a. Informant's Name/Relationship (Type, Print): Marguerite C. Davis (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 807 Westmore Ave., Rockville, MD 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Lincoln Park Cem.

Date: 1/22/01

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: George R. Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one causa on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Brady Cardia — 5 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary Artery Disease — 5 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carl I. Schoenberger MD

29c. License number: D26540

29d. Date signed (Month, Dey, Year): Jan. 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carl I. Schoenberger, 16220 Frederick Rd., Gaithersburg, MD 20879

State Registrar

31. Date filed (Month, Dey, Year): JAN 22 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03332

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hazel Johnston Ellis
2. Date of Death (Month, Day, Year): January 15 2001
3. Time of Death: 5:56pm
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 490-32-2032
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 6, 1917
9. Birthplace (State or Foreign Country): Oklahoma

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Damascus
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 26704 Haney Avenue
10f. Zip Code: 20872
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedant Evar In U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bieck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Public Schools
17. Fether's Nema (First, Middle, Last): William R. Johnston
18. Mother's Name (First, Middle, Meiden Surneme): Ercell Buzzard
19a. Informent's Neme/Reletionship (Type, Print): Glenn K. Ellis/ Husband
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 26704 Haney Avenue, Damascus, Maryland 20872
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or othar plece): Mt. Olivet Cemetery
Dete: 1/20/2001
20c. Location - City or Town, State: Frederick, Maryland
21. Signature of Funerel Service Licensee: Todd D. Wyner
22. Neme and Address of Facility: Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet causad the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert teilure. List only one cause on eech line.

Approximate Interval Between Onset end Deeth

Immediete Cause (Final disease or condition resulting in death): a. Acute Cardiac Dysrthymia — seconds

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last:

b. Due to (or es e consequence of):

c. Dua to (or as a consequance of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Aortic Aneurysm

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Mennar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homlcide 5☐ Pending invastigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and dua to the ceuse(s) and manner steted.

29b. Signature and title of certifier
29c. License number: D38847
29d. Date signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): David Klein M.D. 9901 Medical Center Way Rockville, Maryland 20850

State Registrar

31. Date filed (Month, Dey, Year): JAN 18 2001
32. Registrar's Signeture: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03333

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KATHRYN Froelich
2. Date of Death (Month, Day, Year): January 17 2001
3. Time of Death: 0745A
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 310-14-4446
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 20, 1920
9. Birthplace (State or Foreign Country): Indiana

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12002 Judson Road
10f. Zip Code: 20906
10g. Citizen of What Country?: Unites States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mathematician
16b. Kind of Business/Industry: Higher Education

17. Father's Name (First, Middle, Last): Jacob Henry Froelich
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Wagner

19a. Informant's Name/Relationship (Type, Print): Richard Froelich/Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9816 Wattsbranch Drive, Rockville, MD 20850

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory Inc
Date: Jan 20 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Kevin A. Moody
22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, PA 933 Gist Ave. Silver Spring, MD 20910

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. LYMPHOMA — 1 YR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CONGESTIVE HEART FAILURE
ATRIAL FIBRILATION
DEEP VEIN THROMBOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D 28656
29d. Date signed (Month, Day, Year): JANUARY 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAVI KASSI MD, 15225 SHADY GROVE ROAD, #208, ROCKVILLE, MD 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

b

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03334

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Austin Lewis Filby

2. Date of Death (Month, Day, Year): January 19, 2001

3. Time of Death: 0630

4a. Facility Name (If not institution, give street and number): 813 Montclair Avenue

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-16-0200

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 1, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 813 Montclair Avenue

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Disbributing Company

17. Father's Name (First, Middle, Last): Samuel A. Filby

18. Mother's Name (First, Middle, Maiden Surname): Virginia Loretta Lambert

19a. Informent's Name/Relationship (Type, Print): Gloria Marie Sier/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8826 Reichs Ford Road, Frederick, Maryland 21704

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: Jan. 22, 2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Richard C.C. Basford M00021

22. Name and Address of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic Pancreatic Cancer — 3 M

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 48184

29d. Date signed (Month, Day, Year): 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elhamy Eskander, M.D., 501 West Seventh Street, Frederick, Md. 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03335

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bobby F. Fowler

2. Date of Death Month Day Year: January 16, 2001

3. Time of Death: 8:10 am

4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 242-42-9212

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 17, 1932

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Olney

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 19313 Olney Mill Road

10f. Zip Code: 20832

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: Korean War

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Printer

16b. Kind of Business/Industry: Printing

17. Father's Name *(First, Middle, Last)*: James Taylor Fowler

18. Mother's Name *(First, Middle, Maiden Surname)*: Janey Pearl Fields

19a. Informant's Name/Relationship *(Type, Print)*: Mary F. Fowler / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 19313 Olney Mill Road, Olney, MD 20832

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park

Date: Jan 19 2001

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: John L Chapin. FD

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. ACUTE MYELOGENOUS LEUKEMIA — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

26d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D35635

29d. Date signed *(Month, Day, Year)*: January 16, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Joseph Kaplan 18111 Prince Phil. Dr Olney MD 20832

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03336

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Albert Fountain

2. Date of Death Month / Day / Year: January 19, 2001

3. Time of Death: 5:32 PM

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 483-28-2200

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 18, 1933

9. Birthplace *(State or Foreign Country)*: Iowa

Usual Residence of Decedent

10a. State: New York

10b. County: None

10c. City, Town or Location: New York

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 251 Lexington Avenue

10f. Zip Code: 10016

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman

16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: Charles Frederick Fountain

18. Mother's Name *(First, Middle, Maiden Surname)*: F. Freda Lemke

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Rider/ Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10916 Waxwood Court, Rockville, Maryland 20852

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Onawa Cemetery

Date: 1/27/01

20c. Location - City or Town, State: Onawa, Iowa

21. Signature of Funeral Service Licensee: Michael Stubbs

22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. JERSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. RESPIRATORY FAILURE.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: H51280

29d. Date signed *(Month, Day, Year)*: 1-19-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANUSHIRAVAN DADGAR, M.D., 13219 EXECUTIVE PARK TERRACE, GERMANTOWN, MD 20874

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

WILLIAM FOUNTAIN: EXPIRED, 1/19/01 @ 1732. GF

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03337

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Kenneth Fred Foltz

2. Dete of Death Month Dey Yeer: JANUARY 13, 2001

3. Time of Deeth: 11:18 PM

4e. Facility Neme *(If not institution, give street end number)*: Frederick memorial Hospital

4b. City, Town, or Location of Deeth: Frederick

4c. County of Death: Frederick

Funeral Director

5. Sociel Security Number: 216-38-0198

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthdey)*: 59 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Sept. 21, 1941

9. Birthplece *(Stete or Foreign Country)*: W.VA.

Usual Residence of Decedent

10e. Stete: MD.

10b. County: Frederick

10c. City, Town or Location: Middletown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 8910 Gloria Ave.

10f. Zip Code: 21769

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Merried 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: 1959-1966

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: telecommunications

16b. Kind of Business/Industry: AT & T

17. Fether's Neme *(First, Middle, Lest)*: Fred Ross Foltz

18. Mother's Name *(First, Middle, Meiden Surneme)*: Mina Sweeney

19e. Informent's Name/Reletionship *(Type, Print)*: Matthew Foltz (Son)

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 8910 Gloria Ave., Middletown, MD. 21769

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Lutheran Cemetery

Date: 1/18

20c. Location - City or Town, Stete: Middletown, MD.

21. Signeture of Funeral Service Licensee: ▶ [signature]

22. Neme and Address of Fecility: Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in deeth) e. ASCVD — Years

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

b. Due to (or es a consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Polycythemia.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the deeth certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) end manner steted.

29b. Signeture and title of certifier: ▶ [signature]

29c. License number: D35164

29d. Dete signed *(Month, Day, Yeer)*: JANUARY 17, 2001

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): Andrew Zarick, M.D. 1080 West Patrick Street Frederick, MD 21701

State Registrar

31. Dete filed *(Month, Day, Yeer)*: JAN 19 2001

32. Registrar's Signeture: ▶ [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03338

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PHILLIP JAMES FLOWERS, SR.

2. Date of Death (Month, Day, Year): JANUARY 22, 2001

3. Time of Death: 03:24 AM

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 241-44-8208

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 28 1934

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Montgomery Village

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 37 Docena Court

10f. Zip Code: 20886

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1951

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Entertainer/Singer

16b. Kind of Business/Industry: Entertainment

17. Father's Name (First, Middle, Last): James N. Flowers, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Lizzie Lee Todd

19a. Informent's Name/Relationship (Type, Print): Phillip Flowers, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 37 Docena Court Montgomery Village, Md. 20886

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Harmony Memorial Park | Date: 1-27-01

20c. Location - City or Town, State: Landover, Md.

21. Signature of Funeral Service Licensee: Larry Cuffie

22. Name and Address of Facility: Capitol Mortuary, Inc. 1425 Maryland Ave., NE Washington, DC 20002

GF

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE CARDIAC DYSRHYTHMIA — SECONDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D38847

29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. David Klein, 9901 Medical Center Dr. Rockville, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03339

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Phyllis Clare Fallon

2. Data of Death Month / Day / Year: January 22, 2001

3. Time of Death: 5:27 pm

4a. Facility Name *(If not institution, give street and number)*: 17520 Queen Elizabeth Drive

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 163-28-3715

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Aug. 29, 1937

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Olney

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 17520 Queen Elizabeth Drive

10f. Zip Code: 20832

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bookkeeper

16b. Kind of Business/Industry: Orthodonist

17. Father's Name *(First, Middle, Last)*: John Francis Gallagher

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen McMaster

19a. Informant's Name/Relationship *(Type, Print)*: Karen L. Naber (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17520 Queen Elizabeth Drive Olney, Maryland 20832

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: Jan. 26 2001

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: William T Bl

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Breast Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Metastasis to Liver, Bone

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 17431

29d. Date signed *(Month, Day, Year)*: 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward Gelmann, MD 3800 Resevoir Road, Washington, DC

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Yes (R) cancer reported by D. Barbour

50

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03340

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thelma Rebecca Favorite
2. Date of Death Month Day Year: January 16, 2001
3. Time of Death: 2045
4a. Facility Name *(If not institution, give street and number)*: College View Nursing Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-01-6163
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 27, 1913
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 700 Toll House Avenue
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress
16b. Kind of Business/Industry: Claire Frock

17. Fether's Neme *(First, Middle, Last)*: James Franklin Weddle
18. Mother's Name *(First, Middle, Meiden Surneme)*: Iva Susan Hewitt

19a. Informant's Neme/Relationship *(Type, Print)*: Morris F. Favorite (Son)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1718 Marsue Drive, Hampstead, Maryland 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Blue Ridge Cemetery
Dete: 1/19/01
20c. Location - City or Town, Stete: Thurmont, Maryland

21. Signeture of Funeral Service Licensee: Robert E. Dailey Sr.
22. Neme and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIND ST. THURMONT, MARYLAND 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediete Ceuse (Finel diseese or condition resulting in death) a.	Congestive Heart Failure	12 hours
Due to (or es e consequence of): b.	Diverticulosis	2 years
Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last — Due to (or es a consequence of): c.		
Due to (or es a consequence of): d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Lyle Arlow
29c. License number: D22019
29d. Dete signed *(Month, Day, Year)*: 01-18-01

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): L.E. Halvorsen MD 1475 Taney Ave Frederick, Md 21702

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 18 2001
32. Registrer's Signeture: Benna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03341

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KAREN S. FINE
2. Date of Death (Month, Day, Year): JANUARY 14, 2001
3. Time of Death: 7:00PM
4a. Facility Name (If not institution, give street and number): 19272 WHEATFIELD TERRACE
4b. City, Town, or Location of Death: GAITHERSBURG
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 053-36-8855
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 12, 1944
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: GAITHERSBURG
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 19272 WHEATFIELD TERRACE
10f. Zip Code: 20879
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): SAMUEL FINE
18. Mother's Name (First, Middle, Maiden Surname): ADELINE KALLIN

19a. Informant's Name/Relationship (Type, Print): STEPHEN FINE / BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19272 WHEATFIELD TERRACE, GAITHERSBURG, MD 20879

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): SONS OF ISRAEL | Date: 01-17-01
20c. Location - City or Town, State: MUNCY, NY

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer
22. Name and Address of Facility: DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximate Intervel Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in death): e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last:

b. Due to (or es e consequence of):

c. Due lo (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M.D. (OME)
29c. License number: 015236
29d. Date signed (Month, Day, Year): JANUARY 16, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CARL MARGOLIS, MD 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03342

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MALIN RITHIKRAIKRIANG GURSKI

2. Date of Death Month Day Year: JAN 16 2001

3. Time of Death: 1:35 PM

4a. Facility Name *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 639-09-5373

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 8, 1961

9. Birthplace *(State or Foreign Country)*: Thailand

Usual Residence of Decedent

10a. State: Virginia

10b. County: Loudoun

10c. City, Town or Location: Sterling

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 18 Glengyle Lane

10f. Zip Code: 20165

10g. Citizen of What Country?

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Veterinarian

16b. Kind of Business/Industry: Medicine

17. Father's Name *(First, Middle, Last)*: Somoha Rithikraikriang

18. Mother's Name *(First, Middle, Maidan Surname)*: Mathana Goh

19a. Informant's Name/Relationship *(Type, Print)*: Steve Gurski - Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18 Glengyle Lane Sterling, VA 20165

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Sam Houston Nat'l Cem

Date: Jan 23, 2001

20c. Location - City or Town, Stata: Ft. Sam Houston, Texas

21. Signature of Funeral Service Licensee: Karen L. Woodall

22. Name and Address of Facility: Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310

Physician Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in daath)

a. SEPSIS

Dua to (or as a consaquance of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in death) Last

b. COMPLICATIONS FOR TREATMENT OF RHEUMATOID ARTHRITIS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of causa of daath? 1☐ Yes 2☒ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Numbar, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. Licansa number: D-45356

29d. Data signed *(Month, Day, Year)*: Jan, 18 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MELANIE W. MITCHELL, LCDR, MC, USN

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 033143

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RALPH ROCCO GIORDANO

2. Date of Death Month / Day / Year: JANUARY 17, 2001

3. Time of Death: 5:52 AM

4a. Facility Name *(If not institution, give street and number)*: SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 070-20-1138

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb 3, 1929

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Montgomery Village

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9704 Shadow Oak Drive

10f. Zip Code: 20886

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager

16b. Kind of Business/Industry: Computer

17. Father's Name *(First, Middle, Last)*: Joseph Giordano

18. Mother's Name *(First, Middle, Maiden Surname)*: Alfonsina Giordano

19a. Informant's Name/Relationship *(Type, Print)*: Ursula S. Giordano, Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9704 Shadow Oak Dr., Montgomery Village, MD 20886

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Calvary Cemetery

Date: Jan 23, 2001

20c. Location - City or Town, State: Greenburg, New York

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Dr., Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ISCHEMIC BOWEL

Due to (or as a consequence of):

c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY FAILURE

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD

29c. License number: D26571

29d. Date signed *(Month, Day, Year)*: JANUARY 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IRVING MIZUS, M.D., 4930 DELRAY AVENUE, BETHESDA, MARYLAND 20814

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Ralph Giordano 1-17-01 5:52 AM

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#26per MD 01/24/2001 FCHD

Certificate of Death

Reg. No. 2001 03344

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES DORSEY GRIFFITH

2. Date of Death (Month, Day, Year): January 16, 2001

3. Time of Death: 7:40 A.M.

4a. Facility Name (If not institution, give street and number): 1529 Cloverhill Lane

4b. City, Town, or Location of Death: Knoxville

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 212-38-2772

6. Sex: 1 M 2 F

7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 7,1940

9. Birthplace (State or Foreign Country): Washington,DC

Usual Residence of Decedent

10a. State: Pennsylvania

10b. County: York

10c. City, Town or Location: Etters

10d. Inside City Limits: 1 Yes 2 No

10e. Street and Number: 300 Ridge Rd./ Lot 37

10f. Zip Code: 17319

10g. Citizen of What Country?: United States

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber

16b. Kind of Business/Industry: Plumbing Contractor

17. Father's Name (First, Middle, Last): Dorsey Clemens Griffith

18. Mother's Name (First, Middle, Maiden Surname): Ellen May Sadtler

19a. Interment's Name/Relationship (Type, Print): Hazel Griffith / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 Ridge Rd., Lot 37 / Etters, Pennsylvania 17319

20a. Method of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Rose Cemetery

Date: 1-19-01

20c. Location - City or Town, State: York, Pennsylvania

21. Signature of Funeral Service Licensee: Raymond Peterson

22. Name and Address of Facility: Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — 7 yrs

Due to (or as a consequence of):
b. Pericardial Tamponade — 7 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 ~~Residence~~ 8 Other (Specify) Son's Residence

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 049381Y

29d. Date signed (Month, Day, Year): 1-17-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vankatesh Nadar / 425 N. 21st St. / Camp Hill, PA 17011

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03345

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Bell Grayson
2. Date of Death (Month, Day, Year): January 19, 2001
3. Time of Death: 3:25P.M.
4a. Facility Name (If not institution, give street and number): Carriage Hill- Bethesda
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-01-4883
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 23, 1909
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: none
10b. County: none
10c. City, Town or Location: Washington D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2900 Conn. Ave., N.W.#421
10f. Zip Code: 20008
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Editor
16b. Kind of Business/Industry: U.S. Gov't

17. Father's Name (First, Middle, Last): Joseph William Bell
18. Mother's Name (First, Middle, Maiden Surname): Julia Barnard

19a. Informant's Name/Relationship (Type, Print): Mary Ann Guevara/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2632 Garfield St., N.W. Wash. D.C. 20008

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: Jan 23, 2001
20c. Location - City or Town, State: Silver Spring, Md.

21. Signature of Funeral Service Licensee: ▶ James E. DeVol
22. Name and Address of Facility: DeVol Funeral Home 2222 Wisc. Ave., N.W. Washington, D.C. 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	5 Days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertensive Cardiovascular Disease	Years
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Insulin Dependent Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Marta A. Schneider MD
29c. License number: D26331
29d. Date signed (Month, Day, Year): January 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marta A. Schneider, M.D. 5401 MacArthur Blvd.,N.W.Wash.D.C. 20016

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03346

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELLA M. GOTZ
2. Date of Death Month Day Year: JANUARY 16, 2001
3. Time of Death: 15:00
4a. Facility Name *(If not institution, give street and number)*: MONTGOMERY GENERAL HOSPITAL
4b. City, Town, or Location of Death: OLNEY
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 375 18 2552
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: DEC. 6, 1911
9. Birthplace *(State or Foreign Country)*: WISCONSIN

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: LAYTONSVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5025 GRIFFITH ROAD
10f. Zip Code: 20882
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BEAUTICIAN
16b. Kind of Business/Industry: BEAUTY SHOP

17. Father's Name *(First, Middle, Last)*: BERNARD JACOBY
18. Mother's Name *(First, Middle, Maiden Surname)*: AMELIA (UNKNOWN)

19a. Informant's Name/Relationship *(Type, Print)*: MARION E. IVKOVICH, DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5025 GRIFFITH ROAD, LAYTONSVILLE, MD. 20882

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: METROPOLITAN CREMATORY
Date: 1/17/01
20c. Location - City or Town, State: ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber
22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME
P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NON HODGINS LYMPHOMA — 1 month

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was cese referred to medicel exeminer? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of injury *(Month, Day Year)*
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D 35635
29d. Date signed *(Month, Day, Year)*: January 16, 2001

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): Joseph Krpan, 18111 Prince Phil. Dr Olney, MD 20832

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: ▶ Donna B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 03347

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SARAH E. GORDON

2. Data of Death Month: Jan Day: 11th Year: 2001

3. Time of Death: 12 27 pm

4a. Facility Name *(If not institution, give street and number)*: HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-42-7625

6. Sex: 1☐ M 2☒ F (X)

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: SEPT. 20, 1916

9. Birthplace *(State or Foreign Country)*: CANADA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: BURTONSVILLE

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 15119 LIBERTY GROVE DRIVE

10f. Zip Coda: 20866

10g. Citizen of Whet Country?: UNITED STATES

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Rece - Amarican Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Fathar's Nama *(First, Middle, Last)*: JACOB WORKMAN

18. Mother's Neme *(First, Middle, Meiden Surneme)*: DORA "UNKNOWN"

19a. Informant's Name/Ratationship *(Type, Print)*: NORMAN A. GORDON / SON

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stata, Zip Code)*: 15119 LIBERTY GROVE DR., BURTONSVILLE, MD 20866

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramovel from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: KING DAVID MEMORIAL GARDENS Date: 01/12/01

20c. Location - City or Town, Stata: FALLS CHURCH, VA

21. Signature of Funaral Service Licensee: ▶ Donald S. Stottlemyer

22. Nama and Addrass of Facility: DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Pert1. Entar tha diseasa, or complications that caused the death. Do not entar tha moda of dying, such es cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach line.

Approximate Intarval Between Onset and Death

Immediata Causa (Finat disaase or condition resulting in death)

a. acute cardio-pulmonary arrest

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disaasa or injury that initieted events resulting in death) Last

b. Coronary artery disease

Due to (or es a consequenca of):

c. Sepsis

Dua to (or as a consequance of):

d. gangrenous right lower extremity

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

insulin dependent diabetes mellitus

anemia gastro-esophageal reflux

osteoporosis chronic cerebral ischemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings availeble prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes casa retarrad to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☐ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, death occurred at the tima, dete and place, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: ▶ Consuelo Alvarez

29c. Licanse number: D: 44907

29d. Date signed *(Month, Dey, Year)*: Jan 11th, 2001

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): CONSUELO ALVAREZ 6121 Montrose Road Rockville, MD 20852

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: ▶ Irene B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Gordon, Sally

5

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03348

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Isadore Goldberg
2. Date of Death Month Day Year: January 15, 2001
3. Time of Death: 9:25 AM
4a. Facility Name *(If not institution, give street and number)*: 3 Hearthstone Ct.
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-32-8975
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 12, 1928
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3 Hearthstone Ct.
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: unknown
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Professor
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Rabbi Benjamin Goldberg
18. Mother's Name *(First, Middle, Maiden Surname)*: Norma Mendelsohn

19a. Informant's Name/Relationship *(Type, Print)*: Adelle Goldberg/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3 Hearthstone Ct. Potomac, MD. 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King David Memorial
Date: 1/17/01
20c. Location - City or Town, State: Falls Church, VA.

21. Signeture of Funeral Service Licensee: Donald C. Stottlemyer
22. Name and Address of Facility: Danzansky-Goldberg Memorial. 1170 Rockville Pike. Rockville, MD. 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death) a. Lung Cancer — four m.os

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residenca 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Investigation 8☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier
29c. License number: D33686
29d. Data signed *(Month, Day, Year)*: January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 1811 Rme Philip Dr. Olney MD 20832

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03349

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen E. Glimpse

2. Date of Death Month Day Year: January 21, 2001

3. Time of Death: 9:50am

4e. Facility Name *(If not institution, give street and number)*: Wilson Health Care Center

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 552-12-5032

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 17, 1903

9. Birthplace *(State or Foreign Country)*: Iowa

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 301 Russell Avenue

10f. Zip Code: 20877

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Roy L. Cooper

18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Haines

19a. Informant's Name/Relationship *(Type, Print)*: Brig. Gen. Harold R. Johnson (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11105 Bellavista Drive, Potomac, MD 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 1/22/01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Robert F. DeVol

22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elliot R. Goldstein

29c. License number: D 03581

29d. Date signed *(Month, Day, Year)*: January 22, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Elliot R. Goldstein, M.D., 9410 Old Georgetown Road, Bethesda, MD 20814

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03350

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DIMITRIA ATHENS GLEKAS

2. Date of Death Month Day Year: January 19, 2001

3. Time of Death: 7:45 AM

4e. Facility Name *(If not institution, give street and number)*: 2504 Oakenshield Drive

4b. City, Town, or Location of Death: Potomac

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 467-82-4709

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 11, 1944

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2504 Oakenshield Drive

10f. Zip Code: 20854

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Biack, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / Collega (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Realtor

16b. Kind of Business/Industry: Real Estate

17. Fether's Name *(First, Middle, Last)*: Peter Athens

18. Mother's Name *(First, Middle, Maiden Sumame)*: Julia Alatzas

19a. Informant's Name/Reietionship *(Type, Print)*: Peter G. Glekas (Husband)

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 2504 Oakenshield Dr., ; Potomac, MD 20854

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or othar piece)*: Gate of Heaven Cemetery

Date: 1/22/01

20c. Location - City or Town, Stete: Silver Spring, MD

21. Signeture of Funeral Service Licensee: ▶ Thomas E. Dlombaker

22. Nema end Addrass of Feciiity: JOSEPH GAWLER'S SONS, INC. 5130 Wisconsin Ave., NW; Washington, DC 20016

Physician /Medical Examiner

23a. Part1. Enter the diseese, or compilcetions thet caused the daath. Do not anter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)

a. Metastatic Pancreatic Carcinoma — 11 months

Due to (or es e consequence ot):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest

b.

Due to (or as e consequence of):

c.

Dua to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Pert I.

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yas 2☒ No

24b. Were eutopsy findings availabia prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, tarm, street, tectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) end menner steted.

29b. Signeture and titie of certifier: ▶ Ann Berger, mD

29c. License number: MA063290

29d. Date signed *(Month, Day, Year)*: 1/23/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Ann M. Berger, M.D. 10/2N236 9000 Rockville Pike Bethesda, MD 20892

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: ▶ Anne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03351

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Henry Gleason
2. Date of Death: Month January Day 21 Year 2001
3. Time of Death: 9:05 PM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 720-10-1848
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 26, 1914
9. Birthplace (State or Foreign Country): Erie, PA

Usual Residence of Decedent

10a. State: PA
10b. County: Warren
10c. City, Town or Location: Russell
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: RD # 1
10f. Zip Code: 16345
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dairy Farmer
16b. Kind of Business/Industry: Farming

17. Father's Name (First, Middle, Last): Herman Guilford Gleason
18. Mother's Name (First, Middle, Maiden Surname): Lydia Pillsbury

19a. Informant's Name/Relationship (Type, Print): June Roys-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2233 Kingshouse Rd. Silver Spring, MD 20904

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Pine Grove Cemetery
Date: 1/26/01
20c. Location - City or Town, State: Russell, PA

21. Signature of Funeral Service Licensee: Karen L. Woodall
22. Name and Address of Facility: Metropolitan Funeral Service 5517 Vine Street., Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARCINOMA LUNG — 6 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: 20391
29d. Date signed (Month, Day, Year): JANUARY 22, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR J KELMAN 6525 BELCREST RD, HYATTSVILLE MD 20782

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Anna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03352

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HUBERT B. GIBSON
2. Date of Death: Month JAN Day 17 Year 2001
3. Time of Death: 03:37 PM
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 214-18-8748
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 10, 1916
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 11714 Ellington Drive
10f. Zip Code: 20705
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: 44-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk/Typist
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Hubert B. Gibson, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Evelyn Brown

19a. Informant's Name/Relationship (Type, Print): Luvenia E. Gibson (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11714 Ellington Dr., Beltsville, MD 20705

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Md. Nat'l Mem. Park
Date: 1/23/01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: George R. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Upper GI Bleed	6 hrs
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	MRSA Sepsis	5 wks
Due to (or as a consequence of):		
c.	@ subclavian DVT	2 wks
Due to (or as a consequence of):		
d.	arteriosclerosis	20 yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Acquired Factor VIII deficency

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rita Pabla MD
29c. License number: DO 47707
29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print): RITA PABLA, MD 13621 BALTIMORE AVENUE LAUREL, MD 20707

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: [illegible] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03353

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Adolf V. Genaro

2. Date of Death Month Day Year: January 20, 2001

3. Time of Death: 11:00 PM

4a. Facility Name *(If not institution, give street and number)*: 7401 Westlake Terrace #1013

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 155-28-9486

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 27, 1940

9. Birthplace *(State or Foreign Country)*: New Jersey

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 7401 Westlake Terrace #1013

10f. Zip Code: 20817

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales

16b. Kind of Business/Industry: Computer

17. Father's Name *(First, Middle, Last)*: Adolf V. Genaro

18. Mother's Name *(First, Middle, Maiden Surname)*: Ethel Steinman

19a. Informant's Name/Relationship *(Type, Print)*: Christienne M. Genaro-Long/Dtr.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 29 Marion Avenue, Mt. Kisco, New York 10549

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mary Rest Cemetery

Date: Jan. 25, 2001

20c. Location - City or Town, State: Mahwah, New Jersey

21. Signature of Funeral Service Licensee: Robert A. Pumphrey M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Ischemic Cardiomyophathy

Due to (or as a consequence of):

d. Coronary Artery Disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D0050295

29d. Date signed *(Month, Day, Year)*: January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eric C. Greenberg, MD 9305 Old Georgetown Rd., Bethesda, MD 20814

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Donna G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03354

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gertrude Holl Hutchison

2. Date of Death Month Day Year: January 18, 2001

3. Time of Death: 1:30 AM

4a. Facility Name *(If not institution, give street and number)*: Manor Care-Potomac

4b. City, Town, or Location of Death: Potomac

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 170-10-9584

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 31, 1913

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10714 Potomac Tennis Lane

10f. Zip Code: 20854

10g. Citizen of What Country?: United States

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bieck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; Coliege (1-4or 5+): –

16a. Decedent's Usuei Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Church

17. Father's Name *(First, Middle, Last)*: Jacob Holl

18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth Caffrey

19a. Informant's Name/Relationship *(Type, Print)*: David P. Hutchison/ Son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 5124 Nebraska Avenue, N.W., Washington, DC 20008

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removei from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Fairview Memorial Park

Dete: January 27, 2001

20c. Location - City or Town, State: Elmhurst, Pennsylvania

21. Signature of Funeral Service Licensee: M00689

22. Name and Address of Feciility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Intervei Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Depression

23b. Did tobacco uee contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piace, end due to the cause(s) end menner steted.

29b. Signature end titie of certifier: Sangeetha Murthy

29c. License number: D0055200

29d. Date signed *(Month, Day, Year)*: January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sangeetha Murthy, M.D. 19504 Doctors Drive, Germantown, Maryland 20874

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03355

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth Honickman

2. Date of Death Month Day Year: January 22, 2001

3. Time of Death: 8:50AM

4a. Facility Name *(If not institution, give street and number)*: Manor Care Chevy Chase

4b. City, Town, or Location of Death: Chevy Chase

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 064-09-7601

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 24, 1917

9. Birthplace *(State or Foreign Country)*: Brooklyn, NY.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Olney

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7805 Overwood Dr.

10f. Zip Code: 20832

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor

16b. Kind of Business/Industry: NY City Government

17. Father's Name *(First, Middle, Last)*: Samuel Kaplan

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Rosen

19a. Informant's Name/Relationship *(Type, Print)*: Linda Epstein/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7805 Overwood Dr. Olney, MD. 20832

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Wellwood Cemetery

Date: 1/24/01

20c. Location - City or Town, State: Farmingdale, NY.

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer

22. Name and Address of Facility: Danzansky-Goldberg Memorial. 1170 Rockville Pike. Rockville, MD. 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

GP

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Bronco Pneumonia — Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. —

Due to (or as a consequence of):

c. —

Due to (or as a consequence of):

d. —

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Artherosclerotic Heart Disease

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

5

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D33357

29d. Date signed *(Month, Day, Year)*: 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lee Jonathan Musher, M.D. 5530 Wisconsin Ave., # 1045 Chevy Chase, MD. 20815

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

ASP

01-0265-021

DWIGHT R. HILL
AMENDED#23,27,28 per ME G793 032001 SS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03356

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dwight Randolph Hill
2. Date of Death Month: JANUARY Day: 15 Year: 2001
3. Time of Death: 10:05 P
4a. Facility Name *(If not institution, give street and number)*: FREDERICK MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 186-50-0361
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 41 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 26, 1959
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: PA
10b. County: York
10c. City, Town or Location: Hanover
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 148 Center Street
10f. Zip Code: 17331
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic
16b. Kind of Business/Industry: Auto Body
17. Father's Name *(First, Middle, Last)*: Theodore Vincent Hill
18. Mother's Name *(First, Middle, Maiden Surname)*: Martha Margurite Wise
19a. Informant's Name/Relationship *(Type, Print)*: Theodore Hill / Father
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 42 Breckenridge St. Gettysburg, PA 17325
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Resthaven Crematory
Date: 1/18/01
20c. Location - City or Town, State: Frederick, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Skkot Cody (Licensed Mortician) 44 Tremaine Ct. Baltimore, MD 21244

Physician /Medical Examiner

23a. Part 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. HYPOXIC-ISCHEMIC ENCEPHALOPATHY, PNEUMONIA, AND ACUTE LIVER AND KIDNEY FAILURE AS A CONSEQUENCE OF A CARDIAC ARRHYTHMIA DUE TO COCAINE INTOXICATION ASSOCIATED WITH RESTRAINT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 1-11-01
28b. Time of Injury: 3:22 P M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: subject ingested cocaine
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: van-street
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 7300 Marcie's Choice Ln., Frederick County, MD

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Stephen S. Radentz, M.D.
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: JANUARY 16, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03357

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ollie Claudilla Hebron
2. Date of Death — Month: January Day: 17 Year: 2001
3. Time of Death: 2323
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 578-38-0222
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 17, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Damascus
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11808 Prices Distillery Road
10f. Zip Code: 20872
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): Collega (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Reasons Thomas
18. Mother's Name (First, Middle, Maiden Surname): Sarah Hawkins

19a. Interment's Name/Relationship (Type, Print): Alvin Hebron/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11808 Prices Distillery Road, Damascus, Md 20872

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Pleasant Grove Cemetery — Date: 1/23/2001
20c. Location - City or Town, State: Damascus, Maryland

21. Signature of Funeral Service Licensee: Todd O Wagner
22. Name and Address of Facility: Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrhythmia leading to Cardiac arrest — ½ Hr
Due to (or as a consequence of):
b. Respiratory Insufficiency' Ventilator Dependent
Due to (or as a consequence of):
c. History of Tensium' Pneumothorax.
Due to (or as a consequance of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H Qadir
29c. License number: D46561
29d. Date signed (Month, Day, Year): JAN 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Qadir 20311 Lappans Road Boonsboro Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03358

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth Lee Hodgkinson
2. Date of Death Month Day Year: January 24, 2001
3. Time of Death: 9:00 p.m.
4a. Facility Name *(If not institution, give street and number)*: Potomac Valley Nursing & Wellness Center
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-40-0685
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 29,1905
9. Birthplace *(State or Foreign Country)*: South Dakota

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1235 Potomac Valley Rd.
10f. Zip Code: 20850
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Economist
16b. Kind of Business/Industry: Defence Department Federal Government

17. Father's Name *(First, Middle, Last)*: Carl Swanson
18. Mother's Name *(First, Middle, Maiden Surneme)*: Ida Peterson

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy Whitt / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11821 Farmland Dr., North Bethesda, MD 20852

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Chesapeake Crematory Inc. | Date: Jan. 27 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Dennis A Hardy
22. Name and Address of Facility: Rapp Funeral & Cremation Services Stephen D. Lohrmann P.A. 933 Gist Ave.; Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Irreversible End Stage Congestive Heart Failure — 2 years

Due to (or as a consequenca of):
b. Arteriosclerotic Cardio Vascular Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequenca of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yas 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.
29b. Signeture end title of certifier: James E Wilson Jr MD
29c. License number: D23392
29d. Date signed *(Month, Day, Year)*: January 25, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James E. Wilson, JR. M.D.; 11125 Rockville Pike, Rockville, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #23a, 26, 28c, 1/24/2001, GF, Montg.Co. **Certificate of Death**

Reg. No. 2001 03359

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IRENE ELIZABETH HILL

2. Date of Death: Month 01 Day 17 Year 2001

3. Time of Death: 4:50 am

4a. Facility Name (If not institution, give street and number): North Hampton Manor Nursing Home

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 209-18-2811

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 13, 1924

9. Birthplace (State or Foreign Country): Pennslyvania

Usual Residence of Decedent

10a. State: Florida

10b. County: Hernando

10c. City, Town or Location: Ridge Manor

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 33324 Ohio Ave

10f. Zip Code: 33525

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Michael Belensky

18. Mother's Name (First, Middle, Maiden Surname): Mary Sebesi

19a. Informant's Name/Relationship (Type, Print): Lloyd E. Hill Jr. - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8805 Hawbottom Rd., Middletown, MD 21769

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Florida National Cemetery | Date: 1/22/01

20c. Location - City or Town, State: Bushnell, FL

21. Signature of Funeral Service Licensee: Dennis A. Pittman

22. Name and Address of Facility: Metropolitan Funeral Service Alexandria, VA 22310

GF

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. End stage renal failure — 2 mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertensive nephropathy

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael S. Rudmann MD

29c. License number: D17106

29d. Date signed (Month, Day, Year): 1-17-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL S. RUDMAN, MD 300 S. CHURCH ST. MIDDLETOWN, MD 21769

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03360

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clare Worden Hendee
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 12:45AM
4a. Facility Name *(If not institution, give street and number)*: Manor Care-Bethesda
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-44-7998
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 17, 1908
9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9107 Kirkdale Road
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Forester
16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Worden Churchill Hendee
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Rose Caroline Nash

19a. Informant's Name/Relationship *(Type, Print)*: Myrtle Ann Goetz/Daughter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 9107 Kirkdale Road, Bethesda, Maryland 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Oaklawn Chapel & Gardens
Date: Spring 2001
20c. Location - City or Town, State: Bruce Twp., Michigan

21. Signature of Funeral Service Licensee: [signature] M00198
22. Neme end Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): a. Arrhythmia

Due to (or as a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due lo (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Diabetes Mellitus

23b. **Did tobacco use contribute to the causes of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred lo medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homlcide 5☐ Pending investigation 6☐ Could nol be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature]
29c. License number: D42518
29d. Date signed *(Month, Dey, Year)*: January 22, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Gul Chablani, MD 11119 Rockville Pike, Suite 401, Rockville, MD 20852

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 24 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

30

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 03361

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Elizabeth Heitzman
2. Date of Death — Month: January; Day: 15; Year: 2001
3. Time of Death: 3:00 PM
4a. Facility Name *(If not institution, give street and number)*: Sunrise Assisted Living of Rockville
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 265-20-0975
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 9, 1923
9. Birthplace *(State or Foreign Country)*: Florida

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2 Delphinium Court
10f. Zip Code: 20853
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Adminstrative Officer
16b. Kind of Business/Industry: Atomic Energy Commission

17. Father's Name *(First, Middle, Last)*: Frank Heitzman
18. Mother's Name *(First, Middle, Maiden Surname)*: Veronica Polak

19a. Informant's Name/Relationship *(Type, Print)*: Isabelle H. Barylski /Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2 Delphinium Court, Rockville, Maryland 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Evergreen Cemetery
Date: Jan. 18, 2001
20c. Location - City or Town, State: Gainesville, Florida

21. Signature of Funeral Service Licensee: ▶ [signature] M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dehydration

Due to (or as a consequence of):
b. Decubitus Ulcer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Parkinson's Disease

Due to (or as a consequence of):
d. Osteoporosis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Assisted Living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D43272
29d. Date signed *(Month, Day, Year)*: January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sunita Hanjura, M.D. 809 Veirs Mill Road, #101, Rockville, Maryland 20851

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03362

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: June M. Harrington
2. Date of Death Month / Day / Year: January 23, 2001
3. Time of Death: 3:30 pm
4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-32-3187
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 26, 1924
9. Birthplace *(State or Foreign Country)*: DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3634 BelPre Road Apt 13
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bookkeeper
16b. Kind of Business/Industry: Rodmans

17. Father's Name *(First, Middle, Last)*: Milton F. Rowe
18. Mother's Name *(First, Middle, Maiden Surname)*: Sophie Considine

19a. Informant's Name/Relationship *(Type, Print)*: Dianne Harrington/ Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2407 Rockwood Avenue, Baltimore, MD 21209

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery — Date: Jan 27 2001
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pulmonary Embolism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 38262
29d. Date signed *(Month, Day, Year)*: January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. Mendhiratta, MD 2401 Research Blvd, Suite 340, Rockville, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03363

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elaine Hall
2. Date of Death (Month, Day, Year): January 22, 2001
3. Time of Death: 9:50 PM
4a. Facility Name (If not institution, give street and number): Beverly Health Care of Hagerstown
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-34-7686
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 9, 1935
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10502 Bushwillow Way
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Personal Office
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Thomas Tucker
18. Mother's Neme (First, Middle, Maiden Surname): Thelma Zecker

19e. Informant's Name/Relationship (Type, Print): George Hall, Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10502 Bushwillow Way, Hagerstown, Maryland 21740

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory, Jan. 24, 2001
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Richard E. Stup M00255
22. Name and Address of Facility: Keeney and Basford PA Funeral Home, 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Arrest — 3 days

Due to (or as a consequence ot):
b. Pneumonia and Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Cardiomyopathy

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings avellable prior to complation ot cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and dua to tha cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis ot axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: [signature]
29c. License number: D27898
29d. Date signed (Month, Day, Year): 1/23/001

30. Name and address ot parson who completed cause ot death (Item 23a) (Type, Print): FRANCISCO L. ANDRADE 350 Mill ST, Hagerstown, MD 21740

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03364

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harry William Hart
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 11:50 PM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-03-1744
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 18, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 6225 Quinn Road
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1944-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Estimator
16b. Kind of Business/Industry: Federal Government
17. Father's Name (First, Middle, Last): John Benjamin Hart
18. Mother's Name (First, Middle, Maiden Surname): Mary Virginia Winpigler
19a. Informent's Name/Relationship (Type, Print): Sylvia L. Springer/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6419 Quinn Road, Frederick, Maryland 21701
20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory | Date: Jan 22, 2001
20c. Location - City or Town, State: Smithsburg, MD
21. Signature of Funeral Service Licensee: Kathryn Roberson MO0706
22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CONGESTIVE HEART FAILURE	1 WEEK
Due to (or as a consequence of): b.	MYOCARDIAL INFARCTION (NON-Q WAVE)	4 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Neil Warnick
29c. License number: D47611
29d. Date signed (Month, Day, Year): JANUARY 22, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NEIL WARNICK MD 1475 TANEY AVE #204, FREDERICK MD 21702

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: Geneva B Hoard

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0526-041

PETER HOWARD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED# 23,ptII,27 per ME G793 032001 SS *Certificate of Death*

Reg. No. 2001 03365

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: PETER MARTIN HOWARD

2. Dete of Deeth — Month: JANUARY; Day: 31; Year: 2001

3. Time of Deeth: 10:30A.M.

4e Facility Name *(If not institution, give street and number)*: 103 BIERY STREET

4b. City, Town, or Location of Death: EASTON

4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 220-76-3758

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: NOV 9 1961

9. Birthplece *(Stete or Foreign Country)*: MD

Usual Residence of Decedent

10a. Stete: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 103 BIERY ST

10f. Zip Code: 21601

10g. Citizen of What Country?: USA

11. Marital Stetus: 1 [ ] Never Married 2 [ ] Merried 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Rece - American Indien, Black, Whita, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usuel Occupation *(Give kind of work done duning most of working life. DO NOT use retired)*: CHEF

16b. Kind of Business/Industry: FOOD

17. Father's Neme *(First, Middle, Last)*: LUKE V. HOWARD, SR

18. Mother's Name *(First, Middle, Maiden Surneme)*: ANN HUBBARD

19e. Informent's Neme/Reletionship *(Type, Print)*: LUKE V. HOWARD, SR/FATHER

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: PO BOX 993 EASTON, MD 21601

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: CHESAPEAKE CREMATION CTR

Dete: 02-04-01

20c. Location - City or Town, Stete: STEVENSVILLE, MD

21. Signeture of Funerel Service Licensee: M. L. Newnam III CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in deeth):

a. ACUTE PNEUMONIA WITH FOCAL ORGANIZATION ASSOCIATION WITH FOCAL MYOCARDITIS

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last

b.

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert i.: FATTY LIVER; CHRONIC ALCOHOLISM

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings availeble prior to completion of ceuse of death? 1 [X] Yes 2 [ ] No

25. Was cese referred to medicel examiner? 1 [X] Yes 2 [ ] No

26. Place ot Deeth *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* SCENE

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es stated. 2 [X] **Medical Examiner**: On the besis of examination and/or investigetion, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and menner steted.

29b. Signeture and title of certifier: [signature] M.D.

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: FEBRUARY 1, 2001

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print): Mary G. Ripple MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 07 2001

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 19a& b per inf G792 022301 SS

Certificate of Death

Reg. No. 2001 03366

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): REBECCA JONES

2. Date of Death: Month January Day 23, Year 2001

3. Time of Death: 12:30P.

4a. Facility Name (If not institution, give street and number): 9387 Ridings Way

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 093-12-1674

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb.1,1916

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9387 Ridings Way

10f. Zip Code: 20723

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): John Harris

18. Mother's Name (First, Middle, Maiden Surnama): Isabell unk.

19a. Informant's Name/Relationship (Type, Print): Beverly E. Dixon ~~Betty Dixon~~ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~same as #10a - 10g~~ 57 Wellington Drive, VA 23666-2822

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or othar place): New Mt. Zion Baptist Church Cemetery

Date: 1/27/2001

20c. Location - City or Town, Stata: Gloucester,Virginia

21. Signature of Funeral Service Licensee: By Donald V. Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter tha moda of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death): a. Squamous Cell Lung Cancer — 1yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rita Pabla MD

29c. License number: D0047707

29d. Data signed (Month, Day, Year): January 23, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Rita Pabla, M.D. 13621 Baltimore Avenue Laurel, Maryland 20707

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Lauren B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03367

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET E. JACKSON

2. Date of Death — Month: 01 Day: 16 Year: 2001

3. Time of Death: 1:30 A.M.

4a. Facility Name *(If not institution, give street and number)*: 1418 TANEY AVENUE APT.# B-204

4b. City, Town, or Location of Death: FREDERICK

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 218-24-2097

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 01-29-1922

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: FREDERICK

10c. City, Town or Location: FREDERICK

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1418 TANEY AVENUE APT.# B-204

10f. Zip Code: 21702

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: COOK

16b. Kind of Business/Industry: NURSING HOME

17. Father's Name *(First, Middle, Last)*: ROBERT FLETCHER

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY E. BARNES

19a. Informant's Name/Relationship *(Type, Print)*: CHARLES E. JACKSON/ HUSBAND

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1418 TANEY AVENUE APT.# B-204, FREDERICK, MARYLAND

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: RESTHAVEN MEMORIAL GARDENS

Date: 01-19-01

20c. Location - City or Town, State: FREDERICK, MARYLAND 21702

21. Signature of Funeral Service Licensee: ▶ Jacqueline Keck

22. Name and Address of Facility: STAUFFER FUNERAL HOMES, P.A. 1621 OPOSSUMTOWN PIKE, FREDERICK, MARYLAND 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction — minutes

Due to (or as a consequence of):

b. CORONARY ARTERY Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension — years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D29791

29d. Date signed *(Month, Day, Year)*: 1/18/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARK P. RUBIN 201 THOMAS JOHNSON DRIVE FREDERICK, MD 21702

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001

32. Registrar's Signature: ▶ Bonnie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#17 FCHD,ks 01/24/01 **Certificate of Death** Reg. No. 2001 03368

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner | **Funeral Director** | **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): EDNA BERG JOHNSON
2. Date of Death (Month, Day, Year): JANUARY 21, 2001
3. Time of Death: 3:50 A.M.
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick
5. Social Security Number: 501-74-0684
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/23/1910
9. Birthplace (State or Foreign Country): North Dakota

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2762 Lynn Street
10f. Zip Code: 21704
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): ~~Frederick Berg~~ Fred Berg
18. Mother's Name (First, Middle, Maiden Surname): Louise Schindler
19a. Informant's Name/Relationship (Type, Print): Frederick Johnson/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2762 Lynn Street, Frederick, Maryland 21704
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory
Date: 01/24/2001
20c. Location - City or Town, State: Hagerstown, Maryland
21. Signature of Funeral Service Licensee: Jacqueline L Kuch
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702

Physician /Medical Examiner | **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CONGESTIVE HEART FAILURE	1-2 DAYS
Due to (or as a consequence of): b.	ASPIRATION PNEUMONIA	1-2 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D47611
29d. Date signed (Month, Day, Year): JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NEIL WAXMAN MD 1475 TAMRY AVE #204 FREDERICK MD 21702

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: Bonnie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

#20A

AMEND ITEM: #10A-F G792 2-15-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03369

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SELMA K. KUSHNER

2. Date of Death (Month, Day, Year): JANUARY 15, 2001

3. Time of Death: 2:50 AM

4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 213-40-9040

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUGUST 8, 1921

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD ~~MASS.~~

10b. County: MONTGOMERY ~~NORFOLK~~

10c. City, Town or Location: SILVER SPRING ~~WESTWOOD~~

10d. Inside City Limits: 1☒ Yes 2☐ ~~No~~

10a. Street and Number: 2201 COLSTON DR. #510 ~~195 WOODLAND ROAD~~

10f. Zip Code: 20910 ~~02090~~

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): ALLEN VICTOR KREGER

18. Mother's Name (First, Middle, Maiden Surname): MATTIE DAVIS

19a. Informant's Name/Relationship (Type, Print): JEFFREY L. KUSHNER/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 195 WOODLAND ROAD, WESTWOOD, MASSACHUSETTES 02090

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): KING DAVID MEMORIAL GDNS.

Date: JAN. 21, 2001

20c. Location - City or Town, State: FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee: Donald C. Stottlemyer

22. Name and Address of Facility: DANZANSKY--GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. RESPIRATORY FAILURE

Due to (or as a consequence of):

c. CHRONIC OBSTRUCTIVE PULMONARY

Due to (or as a consequence of):

d. DISEASE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Merlyn Vemury MD.

29c. License number: D35791

29d. Date signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MERLYN VEMURY, M.D. 9801 GEORGIA AVE, SILVER SPRING MD 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Bruce G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28d-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

KUSHNER, SELMA 2:50AM 1/15/01

20

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03370

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Macey Kronsberg

2. Date of Death (Month, Day, Year): January 16, 2001

3. Time of Death: 3 PM

4a. Facility Name (If not institution, give street and number): Manor Care Potomac

4b. City, Town, or Location of Death: Potomac

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 250-07-5271

6. Sex: 1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 11, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: X ☐ Yes 2 ☐ No

10e. Street and Number: 1801 East Jefferson Street, # 110

10f. Zip Code: 20852

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: WW-II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Stock Broker

16b. Kind of Business/Industry: Financial

17. Father's Name (First, Middle, Last): Abraham Kronsberg

18. Mother's Name (First, Middle, Maiden Surname): Lena Jacobson

19a. Informant's Name/Relationship (Type, Print): Sandra J. Kronsberg - Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 9904 Avenel Farm Drive, Potomac, Maryland 20854

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cramation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Eretz Hachaim Cemetery

Date: 1/18/2001

20c. Location - City or Town, State: Beit Shemesn, Israel

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer

22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike, Rockville, Maryland 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — 1 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and ptace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sangeetha Murthy PHYSICIAN

29c. License number: D0055200

29d. Date signed (Month, Day, Year): JANUARY 17 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SANGEETHA MURTHY 19500 DOCTORS DRIVE GERMANTOWN MD 20874

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10 (5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03371

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Blix N. Koones
2. Date of Death Month Day Year: January 13, 2001
3. Time of Death: 1:00 PM
4a. Facility Name *(If not Institution, give street and number)*: 4911 Rockmere Court
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 329-03-0817
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 29, 1909
9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: Fla.
10b. County: Monroe
10c. City, Town or Location: Key Colony Beach
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 440 5th Street
10f. Zip Code: 33051
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker
16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Warren Nichols
18. Mother's Name *(First, Middle, Maiden Surname)*: Frances Cockrell

19a. Informant's Name/Relationship *(Type, Print)*: Charles K. Koones/step-son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4911 Rockmere Ct., Bethesda, Maryland 20816

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory | Date: Jan. 15, 2001
20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: James E Bell
22. Name and Address of Facility: Devol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Progressive Inanition	2 months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Malnutrition, Dehydration	4 months
Due to (or as a consequence of):		
c.	Dysphagia	6 months
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☒ Other *(Specify)* Informant's Residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James Foster
29c. License number: D 1380
29d. Date signed *(Month, Day, Year)*: Jan. 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Foster, M.D. 5530 Wisconsin Ave., #925 Chevy Chase, MD 20815

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: Bruce D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 03372

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jerome E. Korpeck

2. Data of Death Month Day Yaar: Jan. 25, 2001

3. Tima of Death: 12:15A.

4a Facility Nama *(If not institution, giva street and number)*: 9318 Kendale Road

4b. City, Town, or Location of Death: Potomac

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 101-14-1672

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: May26,1924

9. Birthplaca *(Stata or Foreign Country)*: New York

Usual Residence of Dacedant

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 9318 Kendale Road

10f. Zip Code: 20854

10g. Citizen of Whet Country?: United STates

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☒ Yas 2☐ No — If Yes, Giva Yaar or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elamentary/Secondary (0-12): 12 — Collega (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Lawyer

16b. Kind of Business/Industry: LAW

17. Fathar's Nama *(First, Middla, Last)*: Abraham Korpeck

18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Helen unknown

19a. Informant's Name/Relationship *(Type, Print)*: Betty F. Korpeck - wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as #10a - 10g

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar place)*: King David Memorial Garden

Date: 1/28/2001

20c. Location - City or Town, Stata: Falls Church,Va.

21. Signature of Funaral Sarvice Licensee: Donald V Borgwardt

22. Nama and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach line.

Approximata Interval Betwaan Onset and Deeth

Immediata Causa (Final disease or condition rasulting in deeth)

a. Acute Leukemia — 3 months

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last

b. Myelodysplastic Syndrome — 18 years

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifiar: Daniel Rosenblum MD

29c. License number: D04766

29d. Data signed *(Month, Day, Yaar)*: January 25, 2001

30. Nama and address of person who complatad causa of death (Item 23a) (Type, Print): Daniel Rosenblum, M.D. 10400 Connecticut Avenue, #606 Kensington, Maryland 20895

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signatura: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03373

Kiser, Blaine

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Blaine R. Kiser, Sr.

2. Date of Death: Month: January Day: 19 Year: 2001

3. Time of Death: 11:55 pm

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 317-28-1719

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 8, 1932

9. Birthplace (State or Foreign Country): Indiana

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1256 Sugarwood Circle Unit 204

10f. Zip Code: 21221

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1950-1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic

16b. Kind of Business/Industry: State Of Maryland

17. Father's Name (First, Middle, Last): Frank Kiser

18. Mother's Name (First, Middle, Maiden Surname): Ethel Holmes

19a. Informant's Name/Relationship (Type, Print): Donna May Kiser/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1256 Sugarwood Circle Unit 204 Baltimore, MD 21221

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc. | Date: 1/22/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ Laura C. Hardesty

22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock — 24 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Urinary Tract Infection — 10 Days

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Non Hodgkins Lymphoma

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ L Summers MD

29c. License number: RD196693

29d. Date signed (Month, Day, Year): January 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lawanda Summers MD 9000 Franklin Square Drive Baltimore Maryland 21237

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12+1

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03374

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ed Kinloch
2. Date of Death: Month January, Day 20, Year 2001
3. Time of Death: 10:00 PM
4a. Facility Name (If not institution, give street and number): 2707 Afton Street
4b. City, Town, or Location of Death: Temple Hills
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 248-03-0034
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 12/17/1908
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George
10c. City, Town or Location: Temple Hill
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2707 Afton Street
10f. Zip Code: 20748
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cutter
16b. Kind of Business/Industry: Logging Co.

17. Father's Name (First, Middle, Last): Sipore Kinloch
18. Mother's Name (First, Middle, Maiden Surname): Sophie Mitchell

19a. Informant's Name/Relationship (Type, Print): Sandie Kinloch Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2707 Afton St. Temple Hills, MD 20748

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Charity A.M.E. Cemetery
Date: 1/27/01
20c. Location - City or Town, State: Huger, SC

21. Signature of Funeral Service Licensee: Dennis La Pittus
22. Name and Address of Facility: Metropolitan Funeral Service, 5517 Vine St. Alexandria, VA 22310

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cancer Pancreas — 6 mo
Due to (or as a consequence of):
b. Cancer colon — 6 mo
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Alzheimers

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas L Fielding MD
29c. License number: D001923
29d. Date signed (Month, Day, Year): JAN 22 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. L. Fielding MD Waldorf MD 20601

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Donna B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03375

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norma Kent

2. Date of Death (Month, Day, Year): January 15, 2001

3. Time of Death: 1:20am

4a. Facility Name (If not institution, give street and number): The Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 064-36-4101

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 4, 1912

9. Birthplace (State or Foreign Country): Russia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9506 Thornhill Rd.

10f. Zip Code: 20901

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper

16b. Kind of Business/Industry: Health Foods

17. Father's Name (First, Middle, Last): Benjamin Schwartz

18. Mother's Name (First, Middle, Maiden Surname): Sybil Kerewsky

19a. Informant's Name/Relationship (Type, Print): Edith Mahlmann/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9506 Thornhill Rd. Silver Spring, MD. 20901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Menorah Gardens

Date: 1/18/01

20c. Location - City or Town, State: Rockville, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Danzansky-Goldberg Memorial 1170 Rockville Pike. Rockville, MD. 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D 18084

29d. Date signed (Month, Day, Year): JANUARY 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D. D. PATEL, MD · 6121 MONTROSE RD, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03376

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Frank	J	Katen	January 21, 2001	2:00pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manor Care Silver Spring	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
049-01-4938	1☒ M 2☐ F	98 Yrs.			Jan. 21, 1903	New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14717 New Hampshire Avenue	20905	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yaar or Datas:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12	4	Numinmastist	Literature

17. Father's Nama (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Anthony Katen	Ethel Bianca

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
Laurese Katen / Wife	14717 New Hampshire Avenue, Silver Spring, MD 20905

20a. Mathod of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other place)	Data	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment	Gate of Heaven Cemetery	01/24/01	Silver Spring, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jody R Maclary	Hines-Rinaldi 11800 New Hampshire Avenue Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	1 Week
	Due to (or as e consequence of):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events rasulting in death) Last	b. DYSPHAGIA	1 YEAR
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yas 2☒ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ D M Hannon MD	D23124	JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DENNIS M. HANNON, MD 1396 PICCARD DRIVE, ROLKVILLE, MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 25 2001	Anna B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

6F

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03377

Jack Levine

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dr. Jack L. Levine

2. Date of Death: Month January Day 14 Year 2001

3. Time of Death: 5:00 A.M.

4a. Facility Name (If not institution, give street and number): St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 579-10-6841

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 13, 1916

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Montgomery | 10c. City, Town or Location: Rockville | 10d. Inside City Limits: 1 [ ] Yes 2 [ ] No

10e. Street and Number: 12 Ritchfield Ct. | 10f. Zip Code: 20850 | 10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Physician

16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Charles Levine

18. Mother's Name (First, Middle, Maiden Surname): Ethel Friedman

19a. Informant's Name/Relationship (Type, Print): Connie F. Levine/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Ritchfield Ct. Rockville, MD. 20850

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King David Memorial | Date: 1/16/01

20c. Location - City or Town, State: Falls Church, VA.

21. Signature of Funeral Service Licensee: Donald C. Stottlemyer

22. Name and Address of Facility: Danzansky-Goldberg Memorial 1170 Rockville Pike. Rockville, MD. 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Drabetes Mellitus Type II
Due to (or as a consequence of):
b. Viral Gastroenteritis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Alzheimers Disease
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: [signature]

29c. License number: D52097

29d. Date signed (Month, Day, Year): 1/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Janelle M. Bell, MD 55 Stoakley Rd Prince Frederick MD 20678

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03378

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: MILTON LUNCH

2. Deta of Death Month / Day / Year: JANUARY 11, 2001

3. Time of Death: 12:05PM

4e Feclity Neme *(If not institution, give street and number)*: 7112 Kempton Road

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-03-2471

6. Sex: 1☒ M 2☐ F

7. Age *(in yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 12,1917

9. Birthplece *(State or Foreign Country)*: Wash. D.C.

Usual Residance of Decedent

10e. Stete: Md.

10b. County: Prince Georges

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7112 Kempton Road

10f. Zip Code: 20706

10g. Citizen of Whet Country?: U.S.A.

11. Merital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Giva Year or Datas: 1941-1953

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12): / College (1-4or 5+): 4

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Lawyer

16b. Kind of Business/Industry: Engineering & Architectural Law

17. Father's Nama *(First, Middle, Last)*: Morris Lunch

18. Mother's Neme *(First, Middle, Maiden Surname)*: Beatrice Goldberg

19a. Informent's Neme/Reletionship *(Type, Print)*: William Lunch/Nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 154 N.W. 30th Street Corvallis, Oregon 97330

20a. Mathod of Disposition: 1☐ Buriel 2☒ Crametion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or othar place)*: Metropolitan Crematory

Date: Jan. 17, 2001

20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signature of Funerel Service Licensee ▶ James E. Dell

22. Neme end Address of Facility: DeVol Funeral Home 2222 Wisconsin AVe., N.W. Wash. D.C. 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in deeth): e. Myocardial Infarction — Immediate

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in deeth) Last:

b. Arteriosclerosis — 40 Years

Due to (or es a consequence of):

c. Diabetes Mellitus — 40 Years

Dua to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of causa of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, ferm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end dua to the ceuse(s) end menner as stated. 2☐ **Medicat Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier ▶

29c. Licansa number: D00011601

29d. Date signed *(Month, Day, Year)*: January 16, 2001

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Frank C. Blackburn,M.D. 5401 Western Ave., N.W. Wash. D.C. 20015

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 19 2001

32. Registrer's Signeture ▶ Geneva B Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#11 FCHD 01/24/2001 KS *Certificate of Death*

Reg. No. 2001 03379

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Neiper Lyles

2. Date of Death — Month: 01 Day: 20 Year: 2001

3. Time of Death: 8:50A M

4a. Facility Name *(If not institution, give street and number)*: Casey House 6001 Muncaster Mill Road

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery Co.

Funeral Director

5. Social Security Number: 214-30-1433

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 03-05-1927

9. Birthplace *(State or Foreign Country)*: U. S.A

Usual Residence of Decedent

10a. State: MD.

10b. County: Montgomery Co.

10c. City, Town or Location: Rockville, Maryland

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 914 N. Stonestreet Avenue

10f. Zip Code: 20850

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify: Black

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): No

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor--N.I.S.T.-U.S Gov.

16b. Kind of Business/Industry: National Bureau Standards

17. Father's Name *(First, Middle, Last)*: Neiper E. Lyles

18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Sims

19a. Informant's Name/Relationship *(Type, Print)*: Jocelyn A. Washington (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 914 N. Stonestreet Ave.,Rockville,MD. 20850

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resthaven Mem.Gardens

Date: 1-26-2001

20c. Location - City or Town, State: Frederick,Md.

21. Signature of Funeral Service Licensee: Gary L. Rollins

22. Name and Address of Facility: Gary L. Rollins F.H. 110 West South St. Frederick,Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — 12months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____ Due to (or as a consequence of):

c. ____ Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [✓] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D54378

29d. Date signed *(Month, Day, Year)*: 1/26/0,

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Cheryl AYLESWORTH,M.D. 6800Georgia Avenue,Washington,D.C. 20807

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: Gayle G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03380

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances K. Lehman

2. Date of Death (Month, Day, Year): January 16, 2001

3. Time of Death: 5:15AM

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-28-4695

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 19, 1921

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1604 N. Springwood Drive

10f. Zip Code: 20910

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Secretary

16b. Kind of Business/Industry: Applied Physics

17. Father's Name (First, Middle, Last): Arthur Kidwell

18. Mother's Name (First, Middle, Maiden Surname): Marie Leverone

19a. Informant's Name/Relationship (Type, Print): Paul R. Lehman/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1604 N. Springwood Drive, Silver Spring, MD 20910

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rockville Cemetery

Date: Jan 19 2001

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Paul E. Perry, M00803

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. cerebral hemorrhage — 6 hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George J. Sengstack M.D.

29c. License number: D12121

29d. Date signed (Month, Day, Year): Jan. 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George Sengstack, M.D. 3929 Ferrara Drive, Wheaton, Maryland 20906-4709

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03381

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Phyllis Ann Leber

2. Date of Death (Month, Day, Year): January 21, 2001

3. Time of Death: 10:20 am

4a. Facility Name (If not institution, give street and number): Mariner Health Care--Silver Spring

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-36-3491

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 31, 1928

9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 516 Cosgrave Way

10f. Zip Code: 20902

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Horace Daniel Rowell

18. Mother's Name (First, Middle, Maiden Surname): Anna Mae Mann

19a. Informant's Name/Relationship (Type, Print): Gregory Leber/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 516 Cosgrave Way, Silver Spring, MD 20902

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veteran's Cemetery

Date: Jan. 29, 2001

20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: ▶ Andrew J. Cole

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line.

Approximate Interval Between Onsaf and Death

Immediafa Cause (Final disease or condition resulting in deeth)

a. Carcinoma of lung with metastases to bone — weeks

Due to (or as a consequence of):

Sequentially list conditions, if eny, teading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was cese referred to medical exeminer? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Steta)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Barry Rosenbaum

29c. License number: D09834

29d. Date signed (Month, Day, Year): 01/22/01

30. Nama and address of person who completed ceuse of death (item 23a) (Type, Print): Barry Rosenbaum, MD 3720 Farragut Ave, Kensington, MD 20895-2110

State Registrar

31. Data filed (Month, Dey, Year): JAN 23 2001

32. Registrar's Signature: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03382

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna C. Leap

2. Date of Death Month Day Yaar: January 17, 2001

3. Time of Death: 320pm

4a Facility Name *(If not institution, giva street and number)*: 3685 S. Leisure World Dr.

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-01-1335

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Dec 6, 1910

9. Birthplaca *(Stata or Foreign Country)*: VA

Usual Residence of Dacedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3685 S. Leisure World Dr.

10f. Zip Code: 20906

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married ☒3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor

16b. Kind of Business/Industry: Telephone Company

17. Father's Nama *(First, Middle, Last)*: James C. Fopless

18. Mothar's Name *(First, Middle, Maiden Surneme)*: (unknown)

19a. Informant's Name/Relationship *(Type, Print)*: Arsena Larmer /Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3606 Edelmar Terrace, Silver Spring, MD 20906

20a. Method of Disposition: 1☐ Burial ☒2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Date: Jan 24 2001

20c. Location - City or Town, Stata: Beltsville, MD

21. Signeture of Funeral Service Licensee: Beverly L Harbutte

22. Name and Address of Facility: Rapp Funeral Home & Cremation Services 933 Gist Ave. Silver Spring, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in daath)

a. Endstage Chronic Obstructive Pulmonary Disease — 9 Years

Due to (or as a consequence ot):

Sequentially list conditions, if any, leeding to immadiate ceuse. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Lest

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given In Part i.

23b. Did tobacco use contribute to the cause of death? ☒1 Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes ☒2 No

24b. Were autopsy findings availeble prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes ☒2 No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home ☒5 Residence 6☐ Other *(Specify)*

27. Manner of Death: ☒1 Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☒1 **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigetion, In my opinion, deeth occurred at the time, dete end piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D43202

29d. Date signed *(Month, Day, Year)*: January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C Ozanne-Blankfard MD 3305 North Leisure World Blvd Silver Spring Maryland 20906

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 2 6 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03383

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Simon Lajmanovich
2. Date of Death: Month Jan, Day 18, Year 2001
3. Time of Death: 8:00 AM
4a. Facility Name (If not institution, give street end number): Suburban Hospital
4b. City, Town, or Location of Death: Rockville, MD
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-31-2755
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months, Deys | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Dey, Year): Dec. 7 1913
9. Birthplece (Stete or Foreign Country): Argentina

Usuel Residence of Decedent

10e. State: MD
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Streef end Number: 4700 Bradley Blvd.
10f. Zip Code: 20815
10g. Citizen of What Country?: Argentina

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorcad
12. Was Decedenf Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [X] Yes 2 [ ] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12); College (1-4or 5+): 5+
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Chemist
16b. Kind of Business/Industry: pharmaceuticals

17. Fether's Name (First, Middle, Last): Jacobo Lajmanovich
18. Mother'a Name (First, Middle, Melden Surneme): Teresa Orrol

19a. Informant's Neme/Relationship (Type, Print): Ana Gergely/Daughter
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 8217 Windsor View Terrace, Potomac, MD 20854

20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Chesapeake Crematory Inc
Dete: Jan. 23, 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Servica Licensee: Kevin A. Moody
22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, PA 933 Gist Ave. Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Finel diseese or condition resulting in deeth) a.	Metastatic Adenocarcinoma Primary Unknown	2 months
Due to (or as a consequenca of):		
Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditfona** contributing to deafh but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Physicfan:** To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and manner es steted. 2 [ ] **Medicaf Examfner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) end manner stated.

29b. Signeture end fitle of certifier: Anuradha Mendhiratta
29c. License number: D38262
29d. Date signed (Month, Dey, Year): Jan. 18, 2001

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): DR A. Mendhiratta 2401 Research BLVD Suite 340 20850. Rockville MD

State Registrar

31. Date filed (Month, Dey, Year): JAN 22 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, **To the Hospital or Attending Physician:** The law requires thet tha death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03384

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Lymberopoulos Laios
2. Date of Death (Month, Day, Year): Jan. 22, 2001
3. Time of Death: 12:07 PM.
4a. Facility Name (If not institution, give street and number): Casey House , Montgomery Hospice
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-44-8375
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 17, 1909
9. Birthplace (State or Foreign Country): Mass.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10111 Weatherwood Court
10f. Zip Code: 20854
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): George Lymberopoulos
18. Mother's Name (First, Middle, Maiden Surname): Paraskevi Tingos

19a. Informant's Name/Relationship (Type, Print): Diane Bardos - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10111 Weatherwood Ct. Potomac, Md. 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park | Date: 1/25/01
20c. Location - City or Town, State: Rockville, Md.

21. Signature of Funeral Service Licensee: Thomas E. Hondbaker
22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, DC. 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Kaplan
29c. License number: D35635
29d. Date signed (Month, Day, Year): January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Kaplan, MD. 6001 Muncaster Mill Road, Rockville, Md. 20832

State Registrar

31. Date filed (Month, Day, Year): JAN 2 6 2001
32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITE M: #29D PER PHY G792 2-14-01 WR.

Certificate of Death

Reg. No 2001 03385

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Franklin Lady

2. Date of Death: Month Jan. Day 23 Year 2001

3. Time of Death: 6:45 A. M.

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-52-6770

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 85 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 13, 1915

9. Birthplace (State or Foreign Country): Washington, DC.

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 5101 River Road #1403

10f. Zip Code: 20816

10g. Citizen of What Country?: U. S. A.

11. Meritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5 +

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dentist

16b. Kind of Business/Industry: Dentistry

17. Father's Name (First, Middle, Last): George Webster Lady

18. Mother's Name (First, Middle, Maiden Surname): Alta Gotherman

19a. Informant's Name/Relationship (Type, Print): Dorothy E. Lady - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5101 River Road Bethesda, Maryland 20816

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donaiion 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rock Creek Cemetery

Date: 1/26/01

20c. Location - City or Town, State: Washington, D. C.

21. Signature of Funeral Service Licensee: Thomas E. Hombaker

22. Name and Address of Facility: Joseph Gawler's Sons 5130 WI Ave. N.W. Washington, D. C. 20016

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. aspiration pneumonica — 10 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Esophageal Dysmotility

Due to (or as a consequence of):

c. Right middle cerebral

Due to (or as a consequence of):

d. ~~Coronary infarction~~

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Chronic atrial fibrillation

Diabetes II

23b. Did tobacco use contribute to the cauee of death? 1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Menner of Death: 1 ☑ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could nol be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(a) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, dete end place, and dua to the cause(s) and menner steted.

29b. Signature and title of certifier: H. Robert Birschbach DDS

29c. License number: 04115

29d. Date signed (Month, Day, Year): ~~January 23, 2000~~ JANUARY 23, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): H. Robert Birschbach, M. D. 6320 Democracy Blvd. Bethesda, MD 20817-1664

State Registrar

31. Dete filed (Month, Day, Year): JAN 2 6 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

LADY DAVID 1/23/01 0645 AM

15

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 17 PER INFORMANT G792 2-8-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03386

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~GONZALAS MOORE JR.~~ GONZALES MOORE JR.
2. Date of Death Month/Day/Year: 01/ 19/ 2001
3. Time of Death: 3PM
4a. Facility Name (If not institution, give street and number): 8511 CARROLL AVE.
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-56-0662
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 56 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/19/1944
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 8511 CARROLL AVE.
10f. Zip Code: 20903
10g. Citizen of What Country?: U.S.A.
11. Meritel Stetus: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MEAT CUTTER
16b. Kind of Business/Industry: GIANT FOOD
17. Father's Name (First, Middle, Last): ~~GONZALAS MOORE SR.~~ GONZALES MOORE SR.
18. Mother's Name (First, Middle, Maiden Surname): DOROTHY MOORE
19a. Informant's Name/Relationship (Type, Print): MONIQUE MOORE (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7707 OLD CHAPEL DR. BOWIE MD. 20715
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): MT. OLIVET CEMETERY
Date: 01/25/01
20c. Location - City or Town, State: WASHINGTON D.C.
21. Signature of Funeral Service Licensee: Terry A. Austin
22. Name and Address of Facility: AUSTIN ROYSTER FUNERAL HOME 3821 14th ST. N.W. WASH. D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. HEPATOCELLULAR CARCINOMA

Due to (or as a consequenca of): CIRRHOSIS OF THE LIVER — 1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Due to (or as e consequence of):

c. Due fo (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC ALCOHOL ABUSE

23b. Did tobecco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Was en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medicat examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sajeev Anand, M.D.
29c. License number: D-33482
29d. Dete signed (Month, Day, Year): January 24th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sajeev Anand, MD 7343-A Hanover Parkway, Greenbelt, MD 20770

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Steve G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 03387

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Morris Mushinsky
2. Date of Death — Month: January Day: 18 Year: 2001
3. Time of Death: 6:05 A.M.
4a. Facility Name *(If not institution, give street and number)*: Country Home N.H.
4b. City, Town, or Location of Death: Harwood
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-16-5632
6. Sex: 1☐M 2☐F — X
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 13, 1912
9. Birthplace *(State or Foreign Country)*: Wash. D. C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Annes
10c. City, Town or Location: Stevensville
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 515 Buckingham Drive
10f. Zip Code: 21666
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 Years — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Printer
16b. Kind of Business/Industry: Print Shop

17. Father's Name *(First, Middle, Last)*: Harris Mushinsky
18. Mother's Name *(First, Middle, Maiden Surname)*: Sophie Suchetsky

19a. Informant's Name/Relationship *(Type, Print)*: Norman L. Mushinsky - Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 515 Buckingham Drive, Stevensville, Md. 21666

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ohev Sholom Talmud Torah Congregation Cemetery
Date: 1/19/2001
20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: Donald C. Stottlemyer
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause *on* each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Afrial Tachy cardia — 1 wk

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pneumonia
Parkinsons Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wayne Bierbaum, MD
29c. License number: D38563
29d. Date signed *(Month, Day, Year)*: January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wayne Bierbaum, MD 134 Owensville Rd West River MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03388

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Janet G. Moore

2. Date of Death Month Dey Year: January 18, 2001

3. Time of Death: 7:00 pm

4a. Facility Name *(If not institution, give street and number)*: Montgomery Hospice-Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 253-76-7341

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 46 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 6, 1954

9. Birthplace *(State or Foreign Country)*: Georgia

Usual Residence of Decedent

10e. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Brookeville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2920 Dubarry Lane

10f. Zip Code: 20833

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: John Paul Gernatt, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Conaway

19a. Informent's Name/Relationship *(Type, Print)*: George A. Moore,Jr. (husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2920 Dubarry Lane Brookeville,Maryland 20833

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: Jan. 22, 2001

20c. Location - City or Town, State: Alexandria,Virginia

21. Signature of Funeral Service Licensee: ▶ Andrew J. Cole

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Lymphoma of Brain — 7 1/2 Years

Due to (or as a consequence of):

Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 8☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner steted.

29b. Signeture end title of certifier: ▶ E Libre MD

29c. License number: D 09470

29d. Date signed *(Month, Day, Year)*: January 19, 2001

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Eugene P. Libre, M.D. 10400 Connecticut Avenue Kensington, Maryland 20895

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrer's Signeture: ▶ Irene B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03389

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WAYNE E MOURER
2. Data of Death: Month JANUARY Day 16 Year 2001
3. Time of Death: 0220 A
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 529-40-7113
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 5, 1936
9. Birthplace (State or Foreign Country): Colorado

Usual Residance of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 17813 Stoneridge Drive
10f. Zip Code: 20878
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Manager
16b. Kind of Business/Industry: Construction
17. Father's Name (First, Middle, Last): Albert E. Mourer
18. Mother's Name (First, Middle, Maiden Surname): Elma Babbel
19a. Informant's Name/Relationship (Type, Print): Faye L. Mourer (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 17813 Stoneridge Drive Gaithersburg, Md. 20878
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or othar place): Parklawns Mem. Gardens
Data: Jan. 19, 2001
20c. Location - City or Town, State: Chambersburg, Pa.
21. Signature of Funeral Service Licensee: ▶ Curtis E. Day
22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only ona causa on each lina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PANCREATIC ISLET CELL CANCER — 8 YEARS

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:

b. Due to (or as a consequance of):

c. Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medicat examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residanca 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investagation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the tima, date and place, and due to the ceuse(s) and mannar stated.

29b. Signature and title of certifier: ▶ Joseph M. Haggerty MD
29c. License number: D32407
29d. Data signed (Month, Day, Year): JANUARY 16, 2001

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print): JOSEPH M. HAGGERTY 9707 MEDICAL CTR DR ROCKVILLE MD 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signatura: ▶ Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03390

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Maria Isabel Montecinos

2. Date of Death Month / Day / Year: January 16, 2001

3. Time of Death: 11:24 AM

4a Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 053-42-8162

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov 5, 1937

9. Birthplace *(State or Foreign Country)*: Bolivia

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 202 East Franklin Avenue

10f. Zip Code: 20901

10g. Citizen of What Country?: Bolivia

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☒ Yes 2☐ No *Specify:* Bolivian

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Homemaker

16b. Kind of Buainess/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Eliodoro Navia

18. Mother's Name *(First, Middle, Maiden Surname)*: Demetria Arnez

19a. Informant's Name/Relationship *(Type, Print)*: Carmen P. Vargas / Daughter

19b. Maiting Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 202 East Franklin Avenue, Silver Spring, MD 20901

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory | Date: Jan 18 2001

20c. Location - City or Town, State: Alexandria , VA

21. Signature of Funerel Service Licensee: Andrew J. Cole

22. Name end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration of Gastric Contents

Due to (or as a consequence of):
b. Upper Gastrointestinal bleeding

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
c. Advanced Liver Cancer

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James K. Lightfoot, Jr. M.P.

29c. License number: 52326

29d. Date signed *(Month, Day, Year)*: Jan 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James K. Lightfoot, Jr. M.D. 7600 Carroll Ave, Takoma Park , MD 20912

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: Linda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03391

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank Earl Mayne

2. Date of Death: Month: January; Day: 17; Year: 2001

3. Time of Death: 10:50 AM

4a. Facility Name (If not institution, give street and number): 103 Orchard Drive

4b. City, Town, or Location of Death: Thurmont

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 072-07-7391

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 85 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 28, 1915

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Thurmont

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 103 Orchard Drive

10f. Zip Code: 21788

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Superintendent

16b. Kind of Business/Industry: Business Forms

17. Father's Name (First, Middle, Last): Earl F. Mayne

18. Mother's Name (First, Middle, Maiden Surname): Gertrude J. Saunders

19a. Informant's Name/Relationship (Type, Print): Earl Mayne / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Sunset Street Thurmont, Maryland 21788

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Blue Ridge Cemetery

Date: Jan. 20 2001

20c. Location - City or Town, State: Thurmont, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 104 E. Main Street, Thurmont, Maryland 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Brain Tumor

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D44213

29d. Date signed (Month, Day, Year): 1/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ravi Yalamanchili, M.D. 198 Thomas Johnson Drive, #6 Frederick, Md 21702

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03392

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Quinn Milmoe
2. Date of Death (Month, Day, Year): January 16, 2001
3. Time of Death: 7:30 pm
4a. Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-34-7944
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 2, 1928
9. Birthplace *(State or Foreign Country)*: DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10285 Windstream Drive
10f. Zip Code: 21044
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Joseph Quinn
18. Mother's Name *(First, Middle, Maiden Surname)*: Jane Austin

19a. Informant's Name/Relationship *(Type, Print)*: James J. Milmoe, Sr./ Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10285 Windstream Drive, Columbia, MD 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery
Date: Jan 20 2001
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: John L Clyde FD
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceusad the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Septic Shock	1 week
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Cellulitis Abdominal Wall	4 weeks
Due to (or as a consequence of):		
c.		
Due to (or as a consequance of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Deep Vein Thrombosis

Gangrene of Toes

Morbid Obesity

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D39629
29d. Date signed *(Month, Day, Year)*: January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.SY MD 10724 LITTLE PATUXENT PKWY, COLUMBIA MD 21044

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03393

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Jerome McQueeney

2. Date of Death (Month, Day, Year): January 12, 2001

3. Time of Death: 11:58 am

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-24-5222

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 31, 1922

9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4108 Kenny Street

10f. Zip Code: 20705

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Operating Engineer

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Hugh Francis McQueeney

18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Augh

19a. Informant's Name/Relationship (Type, Print): Ida B. McQueeney / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4108 Kenny Street, Beltsville, MD 20705

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Fort Lincoln Cemetery

Date: Jan 19 2001

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Andrew J Cole

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Gastrointestinal Bleed — 5 days

Due to (or as a consequenca of):

b. Duodenal Ulcer — 3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

Due to (or es a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Diabetes

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Margolis MD

29c. License number: D25430

29d. Date signed (Month, Day, Year): 1/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Margolis, MD 13952 Baltimore Ave. Laurel, MD 207

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03394

Physician /Medical Examiner

1. Decedant's Neme *(First, Middle, Last)*: John Robert McLaren
2. Dete of Deeth: Month January Day 21 Yaer 2001
3. Time of Death: 0840
4a Facility Nama *(If not Institution, give street end number)*: Glade Valley Nursing Home
4b. City, Town, or Location of Death: Walkersville
4c. County of Death: Frederick

Funeral Director

5. Sociel Security Number: 214-10-1461
6. Sex: 1☐M 2☐F
7. Aga *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Yeer: Months / Days — If Undar 24 Hrs.: Hours / Min.
8. Deta of Birth *(Month, Day, Year)*: April 16, 1913
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Rasidence of Decedant

10a. Stata: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐Yas 2☐No
10e. Street and Number: 2635 Warren Way
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Merital Status: 1☐Nevar Merried 2☐Married 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1☒Yas 2☐No If Yes, Giva Yaar or Datas: 1943 to 1946
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐Yas 2☒No *Specify:*
14. Rece - American Indian, Black, White, atc. *Specify:* White

15. Decedant's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / Collega (1-4or 5+)
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Master Plumber
16b. Kind of Business/Industry: Plumbing and Heating

17. Fethar's Name *(First, Middle, Last)*: James McLaren
18. Mother's Nama *(First, Middle, Maiden Surname)*: Carrie Poffinberger

19a. Informant's Name/Raletionship *(Type, Print)*: Jane A. Ausherman/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2223 Lamp Post Lane, Frederick, Md. 21701

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Glade Cemetery — Data: January 24, 2001
20c. Location - City or Town, Stata: Walkersville, Md.

21. Signature of Funaral Sarvice Licensee: ▶ Richard C.C. Basford MD0021
22. Name and Address of Facility: Keeney & Basford Funeral Home, 106 East Church Street, Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter tha diseese, or complicetions that caused the deeth. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart feilure. List only one ceuse on each lina. — Approximata Intarval Batween Onsat and Deeth

Immediete Cause (Final diseasa or condition resulting in death): a. ASCVD — 10 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, laeding to immediata cause. Enter Underlying Causa (Diseasa or injury thet initiated events resulting in death) Last:
b.
Due to (or es e consequanca of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☑No

24b. Wara autopsy findings available prior to compiation of cause of death? 1☐Yas 2☑No

25. Was casa rafarred to medical examinar? 1☐Yas 2☑No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA — Other: 4☑Nursing Homa 5☐Rasidanca 6☐Other *(Specify)*

27. Manner of Death: 1☑Naturel 2☐Accident 3☐Suicide 4☐Homicida 5☐Panding invastigetion 6☐Could not be determined

28a. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Dascribe how injury occurred
28e. Data of Injury *(Month, Dey Year)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) end mannar es stated. 2☐**Medical Examiner:** On tha basis of axamination and/or invastigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and mannar stated.

29b. Signatura end titla of cartifiar: ▶
29c. Licanse number: D-31912
29d. Data signed *(Month, Day, Year)*: 1/22/2001

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print): JULIO MENDIOLA / 1564 OPOSSUMTOWN PIKE, FREDERICK, MD 21702

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 22 2001
32. Registrars Signatura: ▶ Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03395

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary K. Monaghan
2. Date of Death: Month: January Day: 20 Year: 2001
3. Time of Death: 4:50 a.m.

4a. Facility Name (If not institution, give street and number): Citizen's Nursing Home
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 164-26-5374
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 30, 1911
9. Birthplace (State or Foreign Country): Scotland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1494 W. 9th Street
10f. Zip Code: 21701
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): James Paton Smith
18. Mother's Name (First, Middle, Maiden Surname): Isabella Kirkness

19a. Informant's Name/Relationship (Type, Print): Isabella Kindness / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 W. Main Street, New Market, Maryland 21774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Steta 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Market Cemetery | Date: 1/23/01
20c. Location - City or Town, State: New Market, Maryland

21. Signature of Funeral Service Licensee: ▶ Jacqueline L Kirk
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. STROKE — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residanca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straat, factory, offica building, etc. (Specify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. Licansa number: D43091
29d. Data signed (Month, Day, Year): 1-22-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAEED TAJDI 801 TOLL HOUSE Ave, Frederick

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: ▶ Donna D Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03396

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eleanor C. McKissick

2. Date of Death Month Day Year: January 23, 2001

3. Time of Death: 5:40 am

4a. Facility Name *(If not institution, give street and number)*: Manor Care- Bethesda

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-34-6784

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept 2, 1909

9. Birthplace *(State or Foreign Country)*: Connecticut

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Garrett Park

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4509 Oxford Street

10f. Zip Code: 20896

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nutritionist

16b. Kind of Business/Industry: Veteran's Administration

17. Father's Name *(First, Middle, Last)*: Matthew J. Crowe

18. Mother's Name *(First, Middle, Maiden Surname)*: Anne Rivers

19a. Informant's Name/Retetionship *(Type, Print)*: Walter Rivers/ Cousin

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 85 Rockwell Avenue, Plainville, CT 06062

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* Entombment

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Gate of Heaven Cemetery | Date: Jan 26 2001

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Eric S Sparks

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Metastatic Squamous Cell Carcinoma of Parotid Gland — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension; Cerebral Atherosclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: L. Albiol MD

29c. License number: D 31319

29d. Date signed *(Month, Day, Year)*: January 24, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): L. Albiol, MD 8218 Wisconsin Ave., Bethesda, MD 20814

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signature: Eric S. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #20b, 1/24/2001, BMW, Montg.Co. — *Certificate of Death* — Reg. No. 2001 03397

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Lansing McKeever
2. Date of Death (Month, Day, Year): January 19, 2001
3. Time of Death: 4:27PM
4a. Facility Name (If not institution, give street and number): 3605 John Carroll Drive
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-34-6486
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 9, 1930
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3605 John Carroll Drive
10f. Zip Code: 20832
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: Korean Conflict
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Realtor Broker
16b. Kind of Business/Industry: Real Estate
17. Father's Name (First, Middle, Last): Robert Livingston McKeever
18. Mother's Name (First, Middle, Maiden Surname): Regina Kellermann
19a. Informant's Name/Relationship (Type, Print): Shirley R. McKeever-Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3605 John Carroll Dr., Olney, Maryland 20832
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Montgomery Crematorium Inc.
Date: January 21, ~~2000~~ 2001
20c. Location - City or Town, Stete: Bethesda, Maryland
21. Signature of Funeral Service Licensee: [signature] M00335
22. Name end Address of Facility: Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Ave. Rockville, Maryland 20850

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediete Cause (Final disease or condition resulting in death)
a. Metastatic Rectal Cancer — 3½ years

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
b.

Due to (or as a consequenca of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury: M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] James G. Brady MD
29c. License number: D07285
29d. Dete signed (Month, Day, Year): January 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James A. Brown, MD 9707 Medical Center Drive, Rockville, Maryland 20850

State Registrar

31. Date filed (Month, Day, ~~Year~~): JAN 22 2001
32. Registrar's Signature: [signature] G. Soaks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

20+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03398

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HOWARD JOSEPH MAYER
2. Date of Death Month: JANUARY Day: 17 Year: 2001
3. Time of Death: 0240 A
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-26-8829
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 7, 1926
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 604 Blandford Street
10f. Zip Code: 20850
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: World War II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): / College (1-4or 5+): 2
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Purchasing Agent
16b. Kind of Business/Industry: Lighting Supply Co.
17. Father's Neme (First, Middle, Last): Ollie J. Mayer
18. Mother's Name (First, Middle, Maiden Surneme): Helen M. Winiesdorffer
19a. Informant's Name/Reletionship (Type, Print): Nellie B. Mayer/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 604 Blandford Street, Rockville, Maryland 20850
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.
Date: January 18, 2000
20c. Location - City or Town, State: Bethesda, Maryland
21. Signature of Funeral Service Licensee: David E. Perry M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC LUNG CANCER — 4 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)
Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending invastigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and placa, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph M. Haggerty MD
29c. License number: D 32407
29d. Data signed (Month, Day, Year): JANUARY 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH M. HAGGERTY MD 9707 MEDICAL CTR DR ROCKVILLE MD 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03399

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANNIE M. MASON

2. Date of Death Month Day Year: JANUARY 19, 2001

3. Time of Death: 12:50 PM

4e. Facility Name *(If not institution, give street and number)*: Collingwood Nursing Center

4b. City, Town, or Location of Death: Rockville

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 218-30-4432

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 99 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June7,1901

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 417 N. Horners Lane

10f. Zip Code: 20850

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th; College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Unknown

18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown

19a. Informant's Name/Relationship *(Type, Print)*: James Mason, Sr., (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 417 N. Horners Lane, Rockville, MD 20850

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington Nat'l Cem.

Date: 1/25/01

20c. Location - City or Town, State: Ft. Myer, VA

21. Signature of Funeral Service Licensee: George R. Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. ST., Rockville, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Alzheimers Disease

Due to (or as a consequenca of):

Sequentially list conditions, if sny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest

b. Congestive Heart Failure

Due to (or as e consequenca of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: A. Seidman MD

29c. License number: D37801

29d. Dete signed *(Month, Day, Year)*: Jan. 23, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): A. Seidman, M.D. 11906 Darnestown Road, Gaithersburg, MD 20878

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrer's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03400

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALICE M. MASON

2. Date of Death (Month, Day, Year): JANUARY 22, 2001

3. Time of Death: 6:04 AM

4a. Facility Name *(If not institution, give street and number)*: Potomac Valley Nursing Home

4b. City, Town, or Location of Death: Rockville

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-44-4679

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 98 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Feb. 28, 1902

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 900 N. Stonestreet Ave.

10f. Zip Coda: 20850

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes ☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* Black

15. Decedent's Education *(Specify only highast grade compiated)*: Elemantary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nursing

16b. Kind of Business/Industry: Medical Services

17. Fathar's Nama *(First, Middla, Last)*: Henry Mason

18. Mother's Nama *(First, Middle, Maiden Surname)*: Mary E. Duffin

19a. Informant's Name/Retationship *(Type, Print)*: Jean Johnson (Daughter)

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 900 N. Stonestreet Ave., Rockville, MD 20850

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Ptace of Disposition *(Name of cemetery, cramatory or other place)*: Lincoln Park Cem.

Date: 1/27/01

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: Sonya R. Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that causad the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each lina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — 48HRS

Due to (or as a consaquenca of):

b. DEMENTIA ALZHEIMERS

Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably ☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings availabla prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residance 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1☑ **Certifying Physician:** To the best of *my* knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, daath occurred at tha tima, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D01120

29d. Data signad *(Month, Day, Year)*: JAN 23 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WALTER E. GOODE MD 1299 LAMBERTON DR WHEATON, MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4 (5)

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03401

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward M. Martin
2. Date of Death (Month, Day, Year): January 20, 2001
3. Time of Death: 5:00 AM
4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 714-07-8756
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 28, 1916
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 961 East West Highway
10f. Zip Code: 20912
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 1943-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Transportation Specialist
16b. Kind of Business/Industry: Defense Dept.

17. Father's Name *(First, Middle, Last)*: Samuel H. Martin
18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth McVeigh

19a. Informant's Name/Relationship *(Type, Print)*: Frances E. Martin / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 961 East West Highway, Takoma Park, MD 20912

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery — Date: 01/23/01
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: Alan J. Donnell
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. SEPSIS	3 DAYS
Due to (or as a consequence of):	b. CONGESTIVE HEART FAILURE	4 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of):	c. ATRIAL FIBRILLATION	4 YEARS
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D. Vikramaditya Reddy MD
29c. License number: D43464
29d. Date signed *(Month, Day, Year)*: JANUARY - 20 - 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIKRAMADITYA REDDY, 11125 ROCKVILLE PIKE, SUITE 208, ROCKVILLE, MD-20852

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001
32. Registrar's Signature: Lorraine G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03402

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Toby Madeoy
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 9:30 PM
4a. Facility Name (If not institution, give street and number): The Hebrew Home of Greater Washington
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 117-12-3324
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 21, 1918
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5225 Pooks Hill Rd. #1118 South
10f. Zip Code: 20814
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Samuel Brownman
18. Mother's Name (First, Middle, Maiden Surname): Rebecca Bendit

19a. Informant's Name/Relationship (Type, Print): Michael Friedman/Son-in-law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8213 Lochinver Lane, Potomac, MD. 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Judean Memorial Gardens
Date: 1/23/01
20c. Location - City or Town, State: Olney, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike. Rockville, MD. 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC CARCINOMA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic lung disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Gregory A Compton MD
29c. License number: D 24942
29d. Date signed (Month, Day, Year): JAN 22 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORY A. COMPTON MD 6121 Montrose Rd Rockville MD

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

GF

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03403

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROMAINE PRIOR MACKIE

2. Date of Death: Month JANUARY Day 16 Year 2001

3. Time of Death: 8:30 AM

4a. Facility Name (If not institution, give street and number): 5111 DALECARLIA DR

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-58-1323

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 103 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 5 1898

9. Birthplace (State or Foreign Country): Ohio

To Be Completed by Funeral Director

Usual Residence of Decedant

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5111 Dalecarlia Drive

10f. Zip Code: 20816

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Reca - American Indian, Black, White, etc. Specify: White

15. Decedant's Education (Specify only highest grade completed): Elementary/Secondery (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor

16b. Kind of Business/Industry: Education

17. Father's Neme (First, Middle, Last): Elmer Prior

18. Mother's Name (First, Middle, Meiden Surname): Ella Jones

19a. Informant's Name/Relationship (Type, Print): Harold F. Golding/Attorney

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1116 Dunoon Road, Silver Spring, MD 20903

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece): Chesapeake Crematory Inc

Data: JAN. 25, 2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Laura C. Hardesty

22. Name end Address of Facility: Rapp Funeral & Cremation Services, 933 Gist Ave. Silver Spring, MD 20910

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or compiications that caused the deth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Acute Coronary Occlusion — Minutes

Due to (or es a consequenca of):

b. Arteriosclerosis — 20 Years

Sequentially list conditions, if any, laading to immediete causa. Entar Undarlying Cause (Disease or Injury thet initieted evants resulting in death) Last

Dua to (or as e consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Osteoarthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residance 6☐ Othar (Specify)

27. Mennar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be datarmined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion and/or invastigation, in my opinion, daath occurred at tha time, data and piece, and dua to the cause(s) and manner stated.

29b. Signeture and title of certifier: [signature] MD

29c. License number: DO 4686

29d. Date signed (Month, Day, Year): January 19, 2001

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Robert F. Dyer, M.D. 5530 Wisconsin Ave. Ste. 540 Chevy Chase, MD 20815-4345

State Registrar

31. Dete filed (Month, Dey, Year): JAN 26 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** 5

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03404

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT WALTER NYE
2. Data of Death Month Day Year: JANUARY 18, 2001
3. Time of Death: 9:00 PM
4a. Facility Name (If not institution, give street and number): CASEY HOUSE
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 034-10-5391
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Yaar: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): Nov 20, 1918
9. Birthplaca (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 331 Broadwood Drive
10f. Zip Code: 20851
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yas 2☐ No If Yes, Give Year or Datas: 1940-1947
13. Was Decedent of Hispanic Origin? (Specify Yaa or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Black, White, atc. Specify: white

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Photographer
16b. Kind of Business/Industry: Medical

17. Fathar's Name (First, Middle, Last): Harold G. Nye
18. Mother's Name (First, Middle, Maiden Surname): Grace Comfort

19a. Informant's Name/Relationship (Type, Print): Caroline M. Nye, Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 331 Broadwood Drive, Rockville, MD 20851

20a. Malhod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, cremetory or other place): Metropolitan Crematory
Date: Jan 22, 2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Gary M. Hess
22. Name and Address of Facility: DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. GLIOBLASTOMA MULTIFORME — 3 MONTHS

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E Libre MD
29c. License number: D09470
29d. Date signed (Month, Day, Year): JANUARY 19, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): EUGENE P. LIBRE, M.D., 10400 CONNECTICUT AVENUE, KENSINGTON, MD 20895

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03405

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES POOL NOWLAND

2. Date of Death (Month, Day, Year): JANUARY 16, 2001

3. Time of Death: 2:29 P.M.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 244-16-0002

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 5, 1919

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Thurmont

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1 West Moser Road

10f. Zip Code: 21788

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Joseph Pool

18. Mother's Name (First, Middle, Maiden Surname): Ellen Apperson

19a. Informent's Name/Relationship (Type, Print): Candy Hattenburg / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7716 Harvest Hills Dr., Mt. Airy, MD 21771

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory

Date: 1/21/01

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Jacqueline Krew

22. Name and Address of Facility: Stauffer Funeral Homes, P.A.
104 E. Main Street, Thurmont, Maryland 21788

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	PNEUMONIA	5 DAYS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	PANCREATITIS	1 WEEK
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE
DIABETES MELLITUS
HYPERTENSION
CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George I. Smith MD VHA

29c. License number: D10587

29d. Date signed (Month, Day, Year): 1/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE I. SMITH M.D. VICE-PRES MED AFFAIRS, FREDERICK MEMORIAL HOSPITAL FREDERICK, MD. 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: Jennifer D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03406

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HATTIE B. NICHOLS

2. Date of Death: Month JAN. Day 19 Year 2001

3. Time of Death: 9:00AM

4a. Facility Name *(If not institution, give street and number)*: LOCK & CHASE HARBORSIDE HEALTH CARE

4b. City, Town, or Location of Death: BOWIE

4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 214 14 0735

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Sept.28, 1909

9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: P.G.

10c. City, Town or Location: DISTRICT HEIGHTS

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7223 MASON STREET

10f. Zip Code: 20747

10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indien, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: VOUCHER EXAMINER

16b. Kind of Business/Industry: FED. GOVT.

17. Father's Name *(First, Middle, Last)*: WALTER JONES

18. Mother's Neme *(First, Middle, Maiden Surneme)*: JULIA RINGOLD

19a. Informant's Name/Relationship *(Type, Print)*: ELAINE BANKS/DAUGHTER

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stata, Zip Code)*: 7223 MASON ST., DIST. HEIGHTS, MD. 20747

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: HARMONY MEM. PK. Dete: 1/25/01

20c. Location - City or Town, Stata: LANDOVER, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Nama end Address of Facility: WATSON F. H.INC. 3435 14th ST., N.W. 20010

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Finel diseese or condition resulting in deeth) a.	Hypertensive CardioVascular Disease	years
Dua to (or es a consequence of): b.	Dementia	years
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Causa (Diseese or Injury that Initieted events resulting in death) Last — Dua to (or es e consequence of): c.	Coronary Atherosclerosis	years
d.	Dysphagia	months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner steted.

29b. Signature end title of certifier: Rakesh arora MD

29c. License number: D20108

29d. Dete signed *(Month, Day, Year)*: 1/25/01

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): RAKESH ARORA, MD 14300 GALLANT FOX LN #222, BOWIE MD 20715

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 25 2001

32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #26, 1/25/2001, GF, Montg. Co.

Certificate of Death

Reg. No. 2001 03407

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARIE ELIZABETH NASH

2. Date of Death (Month, Day, Year): January 5, 2001

3. Time of Death: 1:32 PM

4a. Facility Name (If not institution, give street and number): St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 154-24-6714

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 13, 1918

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County: St. Mary's

10c. City, Town or Location: Lexington Park

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 21650 Galatea Street

10f. Zip Code: 20653

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Francis Brown

18. Mother's Name (First, Middle, Maiden Surname): Cecelia Greenan

19a. Informant's Name/Relationship (Type, Print): Anne Smith - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21650 Galatea Street Lexington Park, MD 20653

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Blendon Central Cemetery

Date: 1/11/01

20c. Location - City or Town, State: Franklin County, Ohio

21. Signature of Funeral Service Licensee: Karen L. Waddell

22. Name and Address of Facility: Metropolitan Funeral Service, 5517 Vine St. Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	probable cardiac arrhythmia	immediate
Due to (or as a consequence of): b.	chronic obstructive lung disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

type 2 diabetes mellitus, kidney cancer, colon polyps

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Fears

29c. License number: B39572

29d. Date signed (Month, Day, Year): 1/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Jonathan Fears, 110 Hospital Rd, Ft. Frederick MD 20678

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #1, 1/30/2001, BMW, Montg.Co.

Certificate of Death

Reg. No. 2001 03408

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy S. Naftulin ~~Dorothy Abrams Naftulin~~

2. Date of Death (Month, Day, Year): January 15, 2001

3. Time of Death: 3:35 A.M.

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 182-09-7105

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 28, 1916

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Montgomery Village

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 19310 Club House Road, Apt. 618

10f. Zip Code: 20886

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator

16b. Kind of Business/Industry: U.S. Gov't Army Hosp.

17. Father's Name (First, Middle, Last): Frank Segal

18. Mother's Name (First, Middle, Maiden Surname): Bessie Benoff

19a. Informant's Name/Relationship (Type, Print): Mervyn Abrams - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12924 Alderleaf Drive, Germantown, Maryland 20874

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Har Jehuda Cemetery | Date: 1/18/2001

20c. Location - City or Town, State: Upper Darby, Pa.

21. Signature of Funeral Service Licensee: Donald C. Stattelmyer

22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Emphysema — 5 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carl Schoenberger MD

29c. License number: D26540

29d. Date signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carl Schoenberger, M. D. 16220 Frederick Rd., # 213, Gaithersburg, Md. 20877

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended item#23b per MD FCHD,ks 1/25/01

Reg. No. 2001 03409

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES LEE OSBORNE

2. Date of Death (Month, Day, Year): JANUARY 19, 2001

3. Time of Death: 9:35 P.M.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 229-78-1657

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 14, 1939

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 28 Sagner Drive

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: Unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Amos Osborne

18. Mother's Name (First, Middle, Maiden Surname): Ida Jean Royal

19a. Informant's Name/Relationship (Type, Print): JoAnn Osborne/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28 Sagner Drive, Frederick, Maryland, 21701

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: 01/23/2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ P. Ryan McMillian

22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — 16 days

Due to (or as a consequence of): (severe) ~~(SEVERE)~~

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — UNKNOWN

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

CORONARY ARTERY DISEASE

CARCINOMA OF THE COLON

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Geo. I. Smith, M.D. VPMA

29c. License number: D10587

29d. Date signed (Month, Day, Year): 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE I. SMITH, M.D. VICE-PRES MED AFFAIRS FREDERICK MEM HOSP. FREDERICK, MD. 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001

32. Registrar's Signature: ▶ Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03410

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Peter Przygocki
2. Date of Death — Month: January Day: 24 Year: 2001
3. Time of Death: 8:40am
4a. Facility Name *(If not institution, give street and number)*: Casey House
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 045-18-6483
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 26, 1924
9. Birthplace *(State or Foreign Country)*: Connecticut

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 801 Nelson Street
10f. Zip Code: 20850
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1942-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amaricen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Spacify only highast grada complated)*: Elementary/Secondery (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Supervisory Linguist
16b. Kind of Business/Industry: Federal Government

17. Fethar's Neme *(First, Middle, Last)*: Henry Vincent Przygocki
18. Mother's Name *(First, Middle, Maiden Sumame)*: Rose Zabek

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy E. Przygocki (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 801 Nelson Street, Rockville, MD 20850

20a. Method of Disposition: 1☐ Buriat 2☒ Cremation 3☐ Removat from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Ptace of Disposition *(Neme of cemetery, crematory or othar piece)*: Metropolitan Crematory
Date: 1/24/01
20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Robert A. DeVol
22. Name end Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications that caused tha death. Do not anter tha mode of dying, such es cardiac or raspiratory errest, shock, or heart failure. List only one causa on each line.

Approximate Interval Between Onset and Deeth

Immediate Ceusa (Final disaese or condition resulting in death)
a. Parkinsons Disease — YEARS

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Lest
b.
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other signifkant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Ptace of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and ptece, end due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or tnvestigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and menner stated.
29b. Signature and title of certifier: Joseph Kaplan
29c. Licansa number: D35635
29d. Date signed *(Month, Day, Year)*: January 24, 2001
30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Joseph Kaplan 18111 Prince Philip Drive, Olney, MD 20832

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 25 2001
32. Registrar's Signature: Bernice B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item #2per MD FCHD 01/22/2001 **Certificate of Death** KS

Reg. No. 2001 03411

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WAYNE EDWARD PALMER

2. Data of Death Month Day Year: ~~JANUARY 18, 2000~~ Jan. 18, 2001

3. Time of Death: 8:05 AM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 164-34-6346

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 10/21,1944

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3045 Basford Road

10f. Zip Code: 21703

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Inspector

16b. Kind of Business/Industry: County Government

17. Father's Name (First, Middle, Last): Emerson Leonard Palmer

18. Mother's Name (First, Middle, Maidan Surname): Winifred Mae Byers

19a. Informant's Name/Relationship (Type, Print): Debra Lynn Palmer/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3045 Basford Road, Frederick, Maryland 21703

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Data: 1/22/2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediata Cause (Final disaasa or condition resulting in death): a. Respiratory Failure — 1 week

Due to (or as a consequence of): Lung Cancer — 6 months

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last:

b. Dua to (or as a consequanca of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D41866

29d. Date signed (Month, Day, Year): January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kanan Hudhud, MD 801 Tollhouse Avenue, F Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03412

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Constance Helen Putnam
2. Date of Death (Month, Day, Year): January 16, 2001
3. Time of Death: 4:10 PM
4a. Facility Name *(If not institution, give street and number)*: 580 Binford Court
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick County

Funeral Director

5. Social Security Number: 555-50-5250
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar. 13, 1938
9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: Virginia
10b. County: Fairfax
10c. City, Town or Location: Falls Church
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2129 Preston Square Court
10f. Zip Code: 22073
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Senior Program Analyst
16b. Kind of Business/Industry: Science Applications

17. Father's Name *(First, Middle, Last)*: George Henry Fitzsimons
18. Mother's Name *(First, Middle, Maiden Surname)*: Erma Marie Hodges

19a. Informant's Name/Relationship *(Type, Print)*: Lisa Wald, daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 580 Binford Court, Frederick, MD 21703

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Crematory
Date: 1/17/2001
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Berger
M00999
22. Name and Address of Facility: Keeney and Basford Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CANCER of PANCREAS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☒ Other *(Specify)* Daughter's Residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jimmy Taylor MD
29c. License number: D29283
29d. Date signed *(Month, Day, Year)*: 1-17-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jimmy Taylor, MD, 10810 Connecticut Ave., Kensington, MD 20895

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03413

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Janice Wilson Pokras

2. Date of Death Month / Day / Year: January 18, 2001

3. Time of Death: 3:00 PM

4a. Facility Name *(If not institution, give street and number)*: 5015 Battery Lane #607

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-03-3841

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 6, 1916

9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5015 Battery Lane #607

10f. Zip Code: 20814

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrative Assistant

16b. Kind of Business/Industry: American Red Cross

17. Father's Name *(First, Middle, Last)*: Not Available/ Wilson

18. Mother's Name *(First, Middle, Maiden Surname)*: Not Available

19a. Informant's Name/Relationship *(Type, Print)*: Bob Pokras/ Step-Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9509 Saginaw Street Silver Spring, Maryland 20901

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium Inc.

Date: January 19, 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] #M00335

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimer's Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D26259

29d. Date signed *(Month, Day, Year)*: January 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ava A. Kaufman, M.D. 4930 Delray Avenue #403 Bethesda, Maryland 20814

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03414

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nettie Podolsky

2. Date of Death Month / Day / Year: January 14, 2001

3. Time of Death: 2:10pm

4a. Facility Name *(If not institution, give street and number)*: Harmony Hall

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 059-36-8712

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 30, 1908

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6336 Cedar Lane # 165

10f. Zip Code: 21044

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner

16b. Kind of Business/Industry: Candy Store

17. Father's Name *(First, Middle, Last)*: Jacob Finer

18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Hirt

19a. Informant's Name/Relationship *(Type, Print)*: Arthur Podolsky/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15101 Interlachen Dr. #1-615 Silver Spring, MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lakeside Memorial Park

Date: 1/15/01

20c. Location - City or Town, State: Miami, FL.

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer

22. Name and Address of Facility: Danzansky-Goldberg Memorial, 1170 Rockville Pike. Rockville, MD. 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Diabetes Mellitus.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

N/A

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* ASSISTED LIVING

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D0042465

29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Sawny MD, 2 Knoll North. Columbia MD 21045.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03415

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Margaret Elizabeth Patton

2. Dete of Deeth — Month: Jan. Day: 17, Year: 2001

3. Time of Death: 5:30 a.m.

4e Facility Neme *(If not institution, give street and number)*: 18413 Kingshill Road

4b. City, Town, or Location of Death: Germantown

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 274-01-3743

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: April 16, 1911

9. Birthplace *(State or Foreign Country)*: OHIO

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 18413 Kingshill Road

10f. Zip Code: 20874

10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementery/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Office Worker

16b. Kind of Business/Industry: Retail Store

17. Father's Name *(First, Middle, Last)*: Joseph Hoobler Minnick

18. Mother's Name *(First, Middle, Maiden Surname)*: Willa Johanna Shaffer

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Olson/ Daughter

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 18413 Kingshill Rd., Germantown, Md. 20874

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetary, crematory or othar place)*: Chesapeake Crematory Inc.

Date: Jan. 20 2001

20c. Location - City or Town, Stete: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Kevin A Hoadley

22. Name and Address of Facility: Rapp Funeral and Cremation Services, Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, Md. 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

a. congestive heart failure — years

Due to (or as a consequence of):

b. ischemic cardiomyopathy — 4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John R. Melnick MD

29c. License number: D19294

29d. Date signed *(Month, Day, Year)*: JANUARY 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN R. MELNICK 911 RUSSELL AVE GAITHERSBURG, Md. 20879

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03416

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James L. Partello
2. Date of Death (Month, Day, Year): January 16, 2001
3. Time of Death: 12:35 pm
4a. Facility Name (If not institution, give street and number): Gladys Spellman Nursing Home
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-07-1375
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 27, 1917
9. Birthplace (State or Foreign Country): (Unknown)

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 13801 Willoughby Rd
10f. Zip Code: 20772
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Contractor
16b. Kind of Business/Industry: Builder

17. Father's Name (First, Middle, Last): (Unknown)
18. Mother's Name (First, Middle, Maiden Surname): (Unknown)

19a. Informant's Name/Relationship (Type, Print): Brian R. Zapp / Personal Rep.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4312 Hamilton Street., Hyattsville, MD 20781

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc.
Date: 1/20/01
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ Laura C. Hardesty
22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Subdural Hematoma
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☐ Natural 2 ☑ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year): November 30, 2000
28b. Time of Injury: 4:00 PM
28c. Injury at Work? 1 ☐ Yes 2 ☑ No
28d. Describe how injury occurred: Patient fell at home
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 13801 Willoughby Rd Upper Marlboro, Maryland 20772

29e. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Salvador Sy MD
29c. License number: H00 55927
29d. Date signed (Month, Day, Year): January 19, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sy MD 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03417

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward Croswell Palmer
2. Deta of Deeth — Month: January; Day: 15; Year: 2001
3. Time of Death: 11:20AM
4a Facility Name *(If not institution, giva street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Deeth: Montgomery

Funeral Director

5. Social Sacurity Numbar: 215-14-7185
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthdey)*: 77 Yrs. — If Under 1 Yaar: Months / Deys; If Undar 24 Hrs.: Hours / Min.
8. Deta of Birth *(Month, Dey, Yeer)*: Jan.26,1923
9. Birthplace *(Stete or Foreign Country)*: Wash. D.C.

Usual Rasidence of Decedent

10a. Stete: Md.
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 8707 Lowell Street
10f. Zip Code: 20817
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yaar or Datas: 1942-1943
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specity Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒No *Specify:*
14. Race - American Indien, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Special Agent
16b. Kind of Business/Industry: F.B.I.

17. Father's Name *(First, Middle, Last)*: William Colton Palmer
18. Mother's Neme *(First, Middle, Maiden Sumame)*: Grace Croswell

19e. Informant's Neme/Relationship *(Type, Print)*: Henry C. Palmer/Son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 8707 Lowell St. Bethesda, Md. 20817

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Metropolitan Crematory
Dete: Jan. 15, 2001
20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signature of Funeral Service Licensee: James E. Bell
22. Neme and Address of Fecility: DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash. D.C. 20007

Physician /Medical Examiner

23a. Print. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one ceuse on aach line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disaasa or condition resulting in deeth)	a. Type I Aortic Dissection	20 Hours
Due to (or as a consequenca of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events rasulting in death) Last	b. Hypertension	15 Years
Due to (or es a consequenca of):		
	c.	
Due to (or es a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to complation of causa of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Sulcida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and pleca, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end piaca, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Roger Stevenson, Jr. M.D.
29c. License number: D-20535
29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Roger Stevenson, Jr. M.D. 6410 Rockledge Drive #200 Bethesda, Md. 20819

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 19 2001
32. Registrar's Signeture: Brenda B Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03418

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tom Edward Paro
2. Date of Death (Month, Day, Year): Jan. 11, 2001
3. Time of Death: 9:30 PM.

4a. Facility Name (If not institution, give street and number): Manor Care Potomac
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 348-16-5997
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 7, 1923
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. Stete: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9100 Kittery Lane
10f. Zip Code: 20817
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW11
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Executive
16b. Kind of Business/Industry: Broadcasting

17. Father's Name (First, Middle, Last): Edward Paro
18. Mother's Name (First, Middla, Maiden Surneme): Alice Price

19a. Informant's Name/Relationship (Type, Print): Dan Paro - Son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 14901 Keeneland Circle, N. Potomac, MD 20878

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other piece): Oak Hill
Date: 1/17/01
20c. Location - City or Town, State: Washington, DC

21. Signeture of Funeral Service Licensee: Thomas E. Hombaker
22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failura. List only ona cause on each line. | Approximate Intarval Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Cerebrovascular Disease
Due to (or es a consequenca of):
b.
Due to (or as a consequence of):
c.
Due fo (or es e consequence of):
d.

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.: Parkinson's Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was casa rafarred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only ona): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physicisn:** To the best of my knowledga, death occurred at the time, date and place, and due to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and placa, and dua to the causa(s) and manner stated.
29b. Signature and title of certifier: Michael J Grady
29c. License number: D0038781
29d. Date signed (Month, Day, Year): Jan. 19, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Michael J. Grady, MD. 4910 Mass Ave. NW. #210, Washington, D.C. 20016-4300

State Registrar

31. Data filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

6F

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03419

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cora Elizabeth Parker
2. Date of Death Month Day Year: January 19, 2001
3. Time of Death: 11:29 pm
4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 412-07-3038
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 19, 1909
9. Birthplace *(State or Foreign Country)*: Arkansas

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3601 Berkenhead Court
10f. Zip Code: 20906
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Human Resources
16b. Kind of Business/Industry: Postal Service

17. Father's Neme *(First, Middle, Last)*: Bonnie Parker
18. Mother's Name *(First, Middle, Meiden Sumeme)*: Eutie Cooke

19a. Informant's Name/Relationship *(Type, Print)*: Frances Lusby/Power of Attorney
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 3601 Berkenhead Court, Silver Spring, MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other placa)*: Fort Lincoln Cemetery
Date: Jan. 23, 2001
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licansee: ▶ Scott L. Smith
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in deeth)	a. Myocardial Infarction	
	Due to (or as a consequence of):	
Sequentially list conditiona, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	b. Atrial Fibrillation	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Non insulin Dependent Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ Wilkinson J. Nirala
29c. License number: D45285
29d. Date signed *(Month, Dey, Year)*: January 20, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): W.J. Nirala, 344 University Blvd #113, Silver Spring, Md

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 23 2001
32. Registrar's Signature: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

15

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03420

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert E. Packman
2. Date of Death Month / Day / Year: January 16, 2001
3. Time of Death: 5:48 PM
4a. Facility Name *(If not institution, give street and number)*: 4515 Willard Ave. #515 S.
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 141-26-9620
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 8,1937
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4515 Willard Ave. #515 S.
10f. Zip Code: 20815
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner
16b. Kind of Business/Industry: Wines/beverages

17. Father's Name *(First, Middle, Last)*: Samuel Packman
18. Mother's Name *(First, Middle, Maiden Surname)*: Fay Weiss

19a. Informant's Name/Relationship *(Type, Print)*: Sylvia Packman/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4515 Willard Ave. #515S. Chevy Chase, MD. 20815

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Beth Kehillah Cemetery
Date: 1/19/01
20c. Location - City or Town, State: Cardiff, NJ.

21. Signature of Funeral Service Licensee: ▶ Donald C. Stoltenberg
22. Name and Address of Facility: Danzansky-Goldberg Memorial. 1170 Rockville Pike. Rockville, MD. 20852

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)
a. Gastrointestinal Hemorrage — Hours

Due to (or es a consequenca of):

Sequentially list conditions, if any, teeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last
b. Pancreatic Carcinoma — 5 Mos.

Due to (or as e consequenca of):
c.

Due to (or es a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and pleca, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D09564
29d. Date signed *(Month, Day, Year)*: January 17, 2001

30. Neme and address of persoo who completed cause of deeth (Item 23e) (Type, Print): Donald A. O'Kieffe, M.D. 5530 Wisconsin Ave. #820 Chevy Chase, MD. 20815

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 2 2 2001
32. Registrer's Signeture: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03421

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Monterville Queen

2. Date of Death (Month, Day, Year): January 25, 2001

3. Time of Death: 8:48 am

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-38-8377

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 18, 1931

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3405 Murdock Road

10f. Zip Code: 20895

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1950-1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4 or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Police Officer

16b. Kind of Business/Industry: Law Enforcement

17. Father's Name (First, Middle, Last): James Ewing Queen

18. Mother's Name (First, Middle, Maiden Surname): Mary E. Kent

19a. Informant's Name/Relationship (Type, Print): Mary Louise Queen / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3405 Murdock Road, Kensington, MD 20895

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Parklawn Memorial Park

Date: Jan 30 2001

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: Eric S Scerbo

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Melanoma to the Brain — chronic

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: WAllmark M.D.

29c. License number: 53177

29d. Date signed (Month, Day, Year): January 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John M. Wallmark, MD 9707 Medical Center Drive, #300, Rockville, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1-2 10 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03422

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Betty Rothouse

2. Date of Death (Month, Day, Year): January 12, 2001

3. Time of Death: 1:45 AM

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 185-36-3224

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 15,1906

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Florida

10b. County: Palm Beach

10c. City, Town or Location: Boca Raton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 10159 Canoe Brook Cir

10f. Zip Code: 33498

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Benjamin Desch

18. Mother's Name *(First, Middle, Maiden Surname)*: Ida (Unknown)

19a. Informant's Name/Relationship *(Type, Print)*: Idele Goldstein Magill/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10159 Canoe Brook Cir. Boca Raton, FL. 33498

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King David Memorial

Date: 1/14/01

20c. Location - City or Town, State: Falls Church, VA.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Danzansky-Goldberg Memorial 1170 Rockville Pike. Rockville, MD. 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Stroke — 3 Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: [signature] Ezzeddine, MD

29c. License number: D56041

29d. Date signed *(Month, Day, Year)*: 01/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mustapha Ezzeddine, M.D. 8600 Old Georgetown Rd. Bethesda, MD. 20814

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ROTHOUSE, BETTY 1:45 1/12/01 AM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03423

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy J. Rosenthal
2. Date of Death Month Day Year: January 12, 2001
3. Time of Death: 1:07 PM
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 119-03-9483
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 16, 1926
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14508 Homecrest Rd. #104
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Alex Jacobson
18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Blecman

19a. Informant's Name/Relationship *(Type, Print)*: Arnold Stuart Rosenthal/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15445 Peach Leaf Dr. Gaithersburg, MD. 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens of King David Memorial
Date: 1/15/01
20c. Location - City or Town, State: Falls Church, VA.

21. Signature of Funeral Service Licensee: Donald C. Stottlemyer
22. Name and Address of Facility: Danzansky-Goldberg Memorial, 1170 Rockville Pike. Rockville, MD. 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Cardiac Dysrhythmia — seconds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Coronary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David Klein MD
29c. License number: 038847
29d. Date signed *(Month, Day, Year)*: January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Klein MD, 9901 Medical Center Dr., Rockville, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03424

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rose Marie Rogers

2. Date of Death (Month, Day, Year): January 19, 2001

3. Time of Death: 7:30 PM

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 176-16-5366

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 14,1917

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4424 Rosedale Avenue

10f. Zip Code: 20814

10g. Citizen of What Country? United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor

16b. Kind of Business/Industry: College

17. Father's Name (First, Middle, Last): Anthony Rogers

18. Mother's Name (First, Middle, Maiden Surname): Mary Brady

19a. Informant's Name/Relationship (Type, Print): Patricia Normile/POA Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10401 Grosvenor Place #1620 North Bethesda,Maryland 20852

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Lawrence Cemetery

Date: January 24,2001

20c. Location - City or Town, State: Houtzdale,Pennsylvania

21. Signature of Funeral Service Licensee: Sue Zephut M00335

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

c. Severe Malnutrition

Due to (or as a consequence of):

d. Unspecified Malabsorption Syndrome

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D0056219

29d. Date signed (Month, Day, Year): 1/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Katarzyna Ostrenska, M.D. 2309 Shorefield Road Silver Spring, Maryland 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Irene G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03425

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN FREDRICK ROBINSON
2. Date of Death (Month, Day, Year): Jan. 20, 2001
3. Time of Death: 10:30am
4a. Facility Name (If not institution, give street and number): Mariner Healthcare of South Md.
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 226-44-8291
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 07/05/38
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Ft. Washington
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2000 Wolf Street
10f. Zip Code: 20744
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1959
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales
16b. Kind of Business/Industry: Sales

17. Father's Name (First, Middle, Last): John Robinson
18. Mother's Name (First, Middle, Maiden Surname): Catherine Collins

19a. Informant's Name/Relationship (Type, Print): Kenneth Robinson (brother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2000 Wolf Street Ft. Washington, Md. 20744

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cremation & Memorial Ctr.
Data: 01/23/01
20c. Location - City or Town, State: Chantilly, Va.

21. Signature of Funeral Service Licensee: R Dulosto
22. Name and Address of Facility: Old Town Funeral Choices 1205 BelleHaven Rd. Alex., Va. 22307

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Bone Cancer	unknown
Due to (or as a consequence of): b.	Amyloidosis	unknown
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	anemia	unknown
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: A Yazdani MD
29c. License number: 50454
29d. Data signed (Month, Day, Year): January 22, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arastoo Yazdani, M.D. 9801 Georgia Ave Suite 3-35 Silver Spring MD 20902

State Registrar

31. Data filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. b

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03426

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rose Ribakoff
2. Date of Death (Month, Day, Year): Jan. 17, 2001
3. Time of Death: 8:05 PM
4a. Facility Name (If not institution, give street and number): 5034 Park Place
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 489-24-0343
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 2, 1910
9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5034 Park Place
10f. Zip Code: 20816
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Civil Service
16b. Kind of Business/Industry: US. Government

17. Father's Neme (First, Middle, Last): Louis Ribakoff
18. Mother's Name (First, Middle, Maidan Surnema): Anna (unknown)

19a. Informent's Neme/Reletionship (Type, Print): Francis E. Yeatman (executor)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 4419 East-West Hwy.; Bethesda, MD 20814

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or othar piece): Cedar Hill Cemetery
Data: 1/30/01
20c. Location - City or Town, Stata: Suitland, Maryland

21. Signature of Funerel Service Licensee: Thomas E. Hombaker
22. Name end Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused tha deeth. Do not enter the mode of dying, such es cardiec or raspiretory arrest, shock, or heert feilure. List only one ceuse on eech line. (Approximete Interval Between Onset and Deeth)

Immediete Ceuse (Finel diseese or condition resulting in deeth): a. Severe Chronic Obstructive Pulmonary Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest:
b.
Due to (or es e consequence of):
c.
Dua to (or as e consequence of):
d.

Part II. Other significant conditions contributing to death but not rasulting in tha underlying causa given in Part I.: Congestive Heart Failure; Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, streat, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end manner as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Ylene A Larsen MD
29c. License number: 13905
29d. Deta signed (Month, Day, Year): Jan. 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ylene A. Larsen, MD. 5454 Wisconsin Ave. #1125, Chevy Chase, Md. 20815-6902

State Registrar

31. Date filed (Month, Day, Year): JAN 2 6 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 03427

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Philip David Ryave

2. Date of Death (Month, Day, Year): January 21, 2001

3. Time of Death: 10:50 P.M.

4a. Facility Name *(If not Institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 182-32-9342

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 21, 1942

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedant

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 850 Geronimo Drive

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1964-1967

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedant's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedant's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Computer Engineer

16b. Kind of Business/Industry: Computer Services

17. Father's Name *(First, Middle, Last)*: Leo Ryave

18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Keebler

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Joan B. Ryave, wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 850 Geronimo Drive, Frederick, Maryland 21701

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Olivet Cemetery, Jan. 25, 2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Richard E. Gray M00255

22. Name and Address of Facility: Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Severe Parkinsons — 1994

Due to (or as a consequence of):
b. Aspiration Pneumonia — 8 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James B. Main

29c. License number: D21944

29d. Date signed *(Month, Day, Year)*: 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JANET S. GRISSOM 300 West Ninth Street, Frederick, Maryland 21701

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: Geneva B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03428

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia Brice Rutledge
2. Date of Death (Month, Day, Year): January 22, 2001
3. Time of Death: 8:10 am
4a. Facility Name (If not institution, give street and number): 8104 Overlook Court
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 213-42-2177
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 03, 1935
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8104 Overlook Court
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Arthur Talbott BRICE
18. Mother's Name (First, Middle, Maiden Surname): Edith Alyce ESTERLY

19a. Informant's Name/Relationship (Type, Print): Katrina B. Kline/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8739 Yellow Springs Road, Frederick, Maryland 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Olivet Cemetery | Date: Jan 26, 2001
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Kathlynn Robertson MO0706
22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Non Small cell Lung Cancer — 11 m

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elhamy Eskander MD
29c. License number: D 48184
29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elhamy Eskander, M.D., 501 West Seventh Street, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: Jessica G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03429

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BESSIE PAULINE RAMSBURG
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 5:30 A.M.
4a. Facility Name (If not institution, give street and number): 11816 Hunt Club Road
4b. City, Town, or Location of Death: Thurmont
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-14-1603
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 12, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Thurmont
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11816 Hunt Club Road
10f. Zip Code: 21788
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Co-Administrator
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Martin I. Harbaugh
18. Mother's Name (First, Middle, Maiden Surname): Bessie Long

19a. Informant's Name/Relationship (Type, Print): Catherine Melinda Icard/ daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11876 Hunt Club Road/ Thurmont, MD 21788

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Memorial Gardens
Date: 01/24/01
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)
a. Cerebral vascular accident — 24 hr
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contributs to the cause of death? 1☐ Yss 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicat Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature]
29c. License number: D 22109
29d. Date signed (Month, Day, Year): 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 1475 Jerry Ave. Frederick Md 21702

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03430

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lwella M Rinker
2. Deta of Deeth: Month 1 Day 23 Yeer 01
3. Time of Death: 1:31 PM
4a. Facility Neme *(If not institution, give street and number)*: Beverly Healthcare
4b. City, Town, or Location of Death: Frederick
4c. County of Deeth: Frederick

Funeral Director

5. Social Sacurity Number: 218-50-3785
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 100 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: Sept 19 1900
9. Birthplece *(Stete or Foreign Country)*: Washington County Maryland

Usuel Residence of Decedent

10e. Steta: MD
10b. County: Frederick
10c. City, Town or Locetion: Brunswick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 220 "A" Street
10f. Zip Code: 21716
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorcad
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Spacify:*
14. Race - American Indian, Bleck, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 6 / College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Businass/Industry: Homemaker

17. Fether's Neme *(First, Middle, Last)*: Edward O. Ausherman
18. Mother's Name *(First, Middle, Meiden Surneme)*: Alice M. Gaylor

19e. Informant's Name/Reletionship *(Type, Print)*: Betty M. Saunders, Daughter
19b. Meiling Address *(Straat and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 601 West "B" Street, Brunswick, MD 21716

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Pleca of Disposition *(Neme of cemetery, cremetory or other pleca)*: Locust Valley Bible Church Cemetery
Date: 1/26
20c. Location - City or Town, Stete: Middletown, MD

21. Signatura of Funerel Service Licensee: Barbara A. Williams
Barbara A. Williams, Owner
22. Name end Address of Facility: John T. Williams Funeral Home
100 Petersville Road, Brunswick, MD 21716

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the moda of dying, such es cardiec or respiratory errest, shock, or haert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel disaasa or condition resulting in deeth)
a. Cerebrouarcular Accident — 10 days
Due to (or es e consaquenca of):
Sequentielly list conditions, if eny, leeding to Immediete ceuse. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Last
b.
Due to (or as e consequance of):
c.
Dua to (or es a consequance of):
d.

Part Ii. **Other significant conditione** contributing to death but not resulting in the undertying ceuse given in Part I.: Gastrointestinal Bleeding

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☑ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Homa 5☐ Rasidenca 6☐ Other *(Specify)*
27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28e. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Pleca of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Straat and Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and piece, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: L Kinland MD
29c. License number: D 22037
29d. Dete signed *(Month, Day, Year)*: 1/24/01

30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print): L KINLAND 610 NINTH AVE BRUNSWICK, MD

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 26 2001
32. Registrers Signature

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03431

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY RAMOS
2. Date of Death (Month, Day, Year): JANUARY 16, 2001
3. Time of Death: 9:20P.M.
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 107-14-7765
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 20, 1915
9. Birthplace (State or Foreign Country): Puerto Rico

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1421 Taney Avenue, # 408
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1☒ Yes 2☐ No Specify: Puerto Rican
14. Race - American Indian, Black, White, etc. Specify: Hispanic

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Juan Ortiz
18. Mother's Nama (First, Middle, Maidan Surnama): Eulalia Cruz

19a. Informant's Name/Relationship (Type, Print): Mrs. Sonia Gadra/Daughter
19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 8407 Stonehouse Road, Frederick, Maryland 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piaca of Disposition (Name of cemetery, cremetory or other place): St. John's Cemetery
Date: Jan 20, 2001
20c. Location - City or Town, Stete: Frederick, MD

21. Signature of Funaral Sarvice Licensee: Kathlyn A Beeson M00706
22. Nama and Address of Faciiity: Keeney & Basford P.A. Funeral Home, 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I: Enter the disease, of complications that caused tha death. Do not antar the moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 96 hrs
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: R. Shapiro M.D.
29c. Licansa number: D07186
29d. Date signed (Month, Day, Year): 1/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Philip J. Shapiro, M.D., 814 Tollhouse Avenue, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03432

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Wilson Rhea, Sr.

2. Data of Death — Month: January; Day: 22; Year: 2001

3. Time of Death: 7:15PM

4a. Facility Name (If not institution, give street and number): Montgomery Hospice Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213-18-3784

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months: ; Days: ; If Under 24 Hrs.: Hours: ; Min.:

8. Date of Birth (Month, Day, Year): Aug. 2, 1921

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12506 Turkey Branch Parkway

10f. Zip Code: 20853

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puarto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Reca - American Indien, Black, White, etc. Specify: White

15. Decedent's Eduoetion (Specify only highest grade completed) — Elementary/Secondery (0-12): 10; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Mechanic/Owner

16b. Kind of Business/Industry: Automotive Repair

17. Father's Name (First, Middle, Last): James Talley Rhea

18. Mothar's Name (First, Middle, Maiden Surneme): Catheren Ann Matheny

19a. Informent's Name/Relationship (Type, Print): Delores Snowden/Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1505 Arbor View Road, Silver Spring, MD 20902

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other pleca): Montgomery Crematorium, Inc.

Data: Jan. 27 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funarel Service Licensea: David E. Perry. M00803

22. Nama end Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not entar tha mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failura. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Final disaasa or condition resulting in death):

a. Coronary Artery Disease — 5 Years

Due to (or as a consequence of):

Sequentially fist conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in death) Last

b. Congestive Heart Failure — Months

Due to (or as a consequence of):

c. Chronic Obstructive Pulmonary Disease

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one) — Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end placa, and due to the cause(s) and menner steted.

29b. Signature and title of certifier:

29c. License number: D35635

29d. Date signed (Month, Dey, Year): January 23, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Kaplan, M.D. 18111 Prince Philip Drive, Olney, Maryland 20832

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03433

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AARON REFSON
2. Date of Death (Month, Day, Year): JAN. 18, 2001
3. Time of Death: 12:30 AM
4a. Facility Name (If not institution, give street and number): MONTGOMERY VILLAGE CARE AND REHAB.
4b. City, Town, or Location of Death: MONTGOMERY VILLAGE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 384-24-1367
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 12, 1931
9. Birthplace (State or Foreign Country): MICHIGAN

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: MONTGOMERY VILLAGE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 19301 WATKINS MILL RD.
10f. Zip Code: 20886
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UNKNOWN
16b. Kind of Business/Industry: UNKNOWN

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Meiden Surneme): UNKNOWN

19a. Interment's Name/Relationship (Type, Print): JANE BLUM/FRIEND
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHAMBERS CREMATORY
Date: 1/19/01
20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W.W. Chambers M00091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., 5801 CLEVELAND AVE. RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such es cardiac or respiretory errest, shock, or heart teilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. CARDIAC ARREST
Due to (or as e consequence ot):
b. SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner ot Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time ot Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, tarm, street, tactory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best ot my knowledge, death occurred at the time, date end piece, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Attan Kasd, M.D., Ph.D.
29c. License number: D55054
29d. Date signed (Month, Day, Year): JANUARY 18, 2001

30. Nama and address ot person who completed ceuse ot death (Item 23a) (Type, Print): ATTAN KASID 17519 REDLAND ROAD ROCKVILLE MD

State Registrar

31. Date tiled (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03434

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen C. Rauner
2. Data of Death Month Day Year: January 18, 2001
3. Tima of Death: 8:00 PM
4a Facility Nama (If not institution, giva street and number): Rockville Nursing Home
4b. City, Town, or Location of Deeth: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Sacurity Number: 091-18-5608
6. Sex: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 103 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 10, 1897
9. Birthplece (State or Foreign Country): New York

Usual Rasidence of Decedant

10a. Stata: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5909 Kingswood Road
10f. Zip Code: 20814
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No. If Yas, Giva Yeer or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementery/Secondary (0-12): 12; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Homemaker
16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama (First, Middla, Last): James M. Miller
18. Mothar's Nama (First, Middla, Maiden Sumama): Anna Heaney

19a. Informant's Name/Relationship (Type, Print): Robert M. Rauner/Son
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 5909 Kingswood Road, Bethesda, Maryland 20814

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): St. Mary's Cemetery
Data: January 26, 2001
20c. Location - City or Town, Stata: Montgomery, New York

21. Signature of Funeral Service Licensee: Ray Lee M00198
22. Nama and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Entar tha diseasa, or complicetions that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory errast, shock, or heart feilura. List only ona causa on aach lina. (Approximate Intarval Batween Onsat and Deeth)

Immediate Causa (Final disaasa or condition resulting in daath):
a. Old Age
Due to (or as a consequance of):
b. Pneumonia

Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disaase or Injury that initiated events resulting in death) Last
Dua to (or as a consequence of):
c.
Dua to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was case refarred to medical examiner? 1☐ Yas 2☒ No
26. Plece of Death (Check only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Rasidanca 6☐ Other (Specify)
27. Mennar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigetion 6☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.

29b. Signature and title of certifier: Frauke Westphal
29c. License number: D0019785
29d. Date signed (Month, Day, Year): January 19, 2001

30. Nama and address of person who completed cause of daath (Item 23e) (Type, Print): Frauke Westphal, M.D., 809 Veirs Mill Road, #101, Rockville, Maryland 20851-1689

State Registrar

31. Data filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signatura: Anne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 094395

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alfred Ramjattan

2. Date of Death Month Day Year: January 23, 2001

3. Time of Death: 9:02 pm

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 217-86-1146

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 22, 1938

9. Birthplace *(State or Foreign Country)*: Trinidad

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9309 Worth Avenue

10f. Zip Code: 20901

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* East Indian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Guest Services

16b. Kind of Business/Industry: National Institutes of Health

17. Father's Name *(First, Middle, Last)*: Loorkhoor Ramjattan

18. Mother's Name *(First, Middle, Maiden Surname)*: Doorlarie Mowsaie

19a. Informant's Name/Relationship *(Type, Print)*: Gregson Ramjattan/ Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9309 Worth Avenue, Silver Spring, MD 20901

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: George Wasington Cemetery

Date: Jan 26 2001

20c. Location - City or Town, State: Adelphi , MD

21. Signature of Funeral Service Licensee: James E Dooley

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Pulmonary Fibrosis — 8 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b. Rheumatoid Arthritis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Victor Steiger MD

29c. License number: D38676

29d. Date signed *(Month, Day, Year)*: JAN 25,01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Victor Steiger, MD 10801 Connecticut Ave., Kensington, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03436

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henderson Alvah Raley
2. Date of Death (Month, Day, Year): January 22, 2001
3. Time of Death: 7:45pm
4a. Facility Name (If not institution, give street and number): 11810 Georgia Avenue
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-01-3747
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 27, 1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11810 Georgia Avenue
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Property Manager
16b. Kind of Business/Industry: Real Estate

17. Father's Name (First, Middle, Last): Alvah Raley
18. Mother's Name (First, Middle, Maiden Surname): Mary Margaret Henderson

19a. Informant's Name/Relationship (Type, Print): John A. Raley / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4987 Morning Star Drive, Dayton, MD 21036

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery — Date: Jan 25 2001
20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: J. Ken Stile
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Arrythmia	1 day
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amit Rajvanshi, MD
29c. License number: D 37891
29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Amit Rajvanshi, MD 121 Congressional Lane #409, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #10E, 17 PER F.H. G792 2-9-01 WR

Certificate of Death

Reg. No. 2001 03437

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY DAVIS SUTER

2. Date of Death (Month, Day, Year): JANUARY 17, 2001

3. Time of Death: 9:04 AM

4a. Facility Name (If not institution, give street and number): WILSON HEALTH CARE AT ASBURY

4b. City, Town, or Location of Death: GAITHERSBURG

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 181-22-3920

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 13, 1924

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 407 RUSSELL AVE. #704 / 704 Russell Ave., Apt. # 403

10f. Zip Code: 20877

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): UNK

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Real Estate Agent

16b. Kind of Business/Industry: Real Estate

17. Father's Name (First, Middle, Last): HORACE N. DAVIS

18. Mother's Name (First, Middle, Maiden Surname): Horace Nicholas Davis / Emma Gilbert Townsend

19a. Informant's Name/Relationship (Type, Print): William Guy Suter/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 407 Russell Ave., Apt 704 Gaithersburg, MD 20877

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Uniformed Services Univer. Date: Jan.19 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Kevin A. Hoody

22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, 933 Gist Ave., Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Carcinoma of Lung	15 Months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Emphysema

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Charles M. Benner

29c. License number: D31563

29d. Date signed (Month, Day, Year): January 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles M. Benner, M.D. 11251 Lockwood Drive, Silver Spring, MD 20901

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Jeanne B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03438

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): XVONNE STEWART

2. Date of Death (Month, Day, Year): JAN 23, 2001

3. Time of Death: 4:00 Am

4a. Facility Name (If not institution, give street and number): MANOR CARE Nursing Home

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 337-16-6616

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct.10,1921

9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: D.C.

10b. County: None

10c. City, Town or Location: WASHINGTON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8301 East Beach Dr,N.W.

10f. Zip Code: 20012

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12) | Collega (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Oscar L. Walker

18. Mother's Name (First, Middle, Maiden Surname): Ethel Machen

19a. Informant's Name/Relationship (Type, Print): Derryl King- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8301 East Beach Dr,Washington,D.C. 20012

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): The Homewood Cemetery

Date: 1-27-2001

20c. Location - City or Town, State: Pittsburg,Pa.

21. Signature of Funeral Service Licensee: Jane de Mateo

22. Name and Address of Facility: Universal II Mortuary Inc. 411Kennedy St,N.W.,Washington,D.C.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Batween Onset and Deeth

Immediata Cause (Final disease or condition resulting in daath)
e. Pneumonia and Urosepsis

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Ceuse (Disease or Injury thet initieted events rasulting in daath) Last
b.
Dua to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jenny Moy

29c. License number: D43260

29d. Date signed (Month, Day, Year): January 24,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jenny Y. Moy,M.D. 13952 Baltimore Ave,Laurel,Maryland 20707

State Registrar

31. Data filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Bruce B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03439

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dallas E. Steele

2. Date of Death Month Day Year: January 17, 2001

3. Time of Death: 7:30 PM

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-42-8596

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 2, 1933

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9932 Mayfield Drive

10f. Zip Code: 20817

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager

16b. Kind of Business/Industry: Security Systems

17. Father's Name *(First, Middle, Last)*: Frederick W. Steele

18. Mother's Name *(First, Middle, Maiden Surname)*: Katherine M. Flynn

19a. Informant's Name/Relationship *(Type, Print)*: Katherine S. Hicks/ Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9932 Mayfield Drive Bethesda, Maryland 20817

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Parklawn Memorial Park

Date: January 21,2001

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Barry Hughart M00335

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SMALL CELL LUNG CARCINOMA — 7 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Victor Priego

29c. License number: 023308

29d. Date signed *(Month, Day, Year)*: JAN 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Victor M. Priego, M.D. 6410 ROCKLEDGE DR #625 BETHESDA, MARYLAND 20817

State Registrar

31. Date filed *(Month, Day, Year)*

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

STEELE, DALLAS 1/17/01 - 0730PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03440

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Karen L. Stamates

2. Date of Death (Month, Day, Year): January 22, 2001

3. Time of Death: 6:56 pm

4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-60-0304

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 4, 1947

9. Birthplace *(State or Foreign Country)*: DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4107 Heathfield Road

10f. Zip Code: 20853

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrative Assistant

16b. Kind of Business/Industry: Title Research

17. Father's Name *(First, Middle, Last)*: Arthur Eugene Lizear

18. Mother's Name *(First, Middle, Maiden Surname)*: Eunice Hale

19a. Informant's Name/Relationship *(Type, Print)*: Richard Lewis Nashwinter/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4107 Heathfield Road, Rockville, MD 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: Jan 25 2001

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Robert E Ramsey

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. GRAM NEGATIVE SEPSIS — 72 HR.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Obj. Mg., MD

29c. License number: D23630

29d. Date signed *(Month, Day, Year)*: January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Fredk J. Mayo, MD 16226 Frederick Rd #213, Gaithersburg, MD 20877

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03441

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gilbert McLin Stockton

2. Date of Death Month: January Day: 20, Year: 2001

3. Time of Death: 7:07 PM

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hosptial

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 252-09-9193

6. Sex: 1 X M 2 ☐ F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 21, 1914

9. Birthplace *(State or Foreign Country)*: Arkansas

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 6888 Crabapple Court

10f. Zip Code: 21703

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1942-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 4

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Training & District Mgr.

16b. Kind of Business/Industry: Control Data Corp.

17. Father's Name *(First, Middle, Last)*: Oregon M. Stockton

18. Mother's Name *(First, Middle, Maiden Surname)*: Harriet Zimmerman

19a. Informant's Name/Relationship *(Type, Print)*: Mary Louise Musser, daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 100 East Church Street, Frederick, MD 21701

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery | Date: 1/24/2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Basford

MO0999

22. Name and Address of Facility: Keeney and Basford Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA — 2 DAYS

Due to (or as a consequence of):

b. MULTIPLE STROKES — 4 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death *(Check only one)*: Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neil Warnick MD

29c. License number: D47611

29d. Date signed *(Month, Day, Year)*: January 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NEIL WARNICK MD 1475 Taney Ave #204 Frederick MD 21702

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03442

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mabel Claire Overby Smith

2. Date of Death (Month, Day, Year): January 15, 2001

3. Time of Death: 6:00 PM

4a. Facility Name (If not institution, give street and number): Montgomery Village Care and Rehabilatation

4b. City, Town, or Location of Death: Montgomery Village

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 252-07-5795

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 5, 1911

9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15609 Yellowhorn Court

10f. Zip Code: 20853

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): -

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Clerk

16b. Kind of Business/Industry: Factory

17. Father's Name (First, Middle, Last): John Overby

18. Mother's Name (First, Middle, Maidan Surname): Sarah Josephine Gable

19a. Informant's Name/Relationship (Type, Print): Charles Bruce Smith/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15609 Yellowhorn Court, Rockville, MD 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Oak Hill Cemetery

Date: January 23, 2001

20c. Location - City or Town, State: Newnan, Georgia

21. Signature of Funeral Service Licensee: M00689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — Minutes

Due to (or as a consequance of):

b. Ischemic Cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation; Diabetes; Congestive Heart Failure; Mitral Valve Regurgitation; Pulmonary Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Robert Birschbach M.D.

29c. License number: D04115

29d. Date signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): H. Robert Birschbach, M.D. 6320 Democracy Blvd., Bethesda, Maryland 20817-1664

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03443

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kenneth. G Smith
2. Date of Death Month / Day / Year: Jan 23rd 2001
3. Time of Death: 05:10 AM
4a. Facility Name *(If not institution, give street and number)*: Baltimore VA Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: None

Funeral Director

5. Social Security Number: 215-62-7390
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 47 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 1, 1953
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residance of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: California
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 502 Horsley Court
10f. Zip Code: 20619
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yaar or Datas: 1970/1975
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mover
16b. Kind of Business/Industry: Moving Company

17. Father's Name *(First, Middle, Last)*: Darrell Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Freda Beckner

19a. Informant's Name/Relationship *(Type, Print)*: Margaret Curry/Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17110 Longdraft Road, House B, Gaithersburg, MD 20878

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 1/26/01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Michael D Sullivan
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only* one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or es a consequenca of):

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Last
b.
Due to (or es a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Liver failure
Renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Sunguk Jang
29c. License number: P13381
29d. Date signed *(Month, Day, Year)*: Jan 23rd 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sunguk Jang 22 S. Greene St. Baltimore MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

GF

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03444

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Earl Simmons
2. Date of Death (Month, Day, Year): Jan. 18 2001
3. Time of Death: 6:25 AM
4a. Facility Name (If not institution, give street and number): Casey House Hospice
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 562-82-0370
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 30, 1951
9. Birthplace (State or Foreign Country): California

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6206 Winston Drive
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1971-1973
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Musician-Guitar
16b. Kind of Business/Industry: Entertainment

17. Father's Name (First, Middle, Last): Clifford Robert Simmons
18. Mother's Name (First, Middle, Maiden Surname): Florence Lorene Hagan

19a. Informant's Name/Relationship (Type, Print): Jill Nielsen/Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6206 Winston Drive, Bethesda, MD 20817

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Cemetory Inc
Date: Jan. 22 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Kevin A Hoody
22. Name and Address of Facility: Rapp Funeral & Cremation Services
Stephen D. Lohrmann, PA 933 Gist Ave.
Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
26b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D 15046
29d. Date signed (Month, Day, Year): January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Newman, M.D., 19261 Montgomery Village Ave., Montgomery Village, MD 20886

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

5+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03445

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charlotte Scaglia
2. Date of Death Month / Day / Year: 01 / 17 / 2001
3. Time of Death: 03:45
4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 088-07-8927
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Nov. 18, 1914
9. Birthplace *(State or Foreign Country)*: Germany

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5594 Teakwood Court
10f. Zip Code: 21701
10g. Citizen of Whet Country?: USA

11. Merital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complated)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Home

17. Father's Neme *(First, Middle, Last)*: Peter Gallina
18. Mother's Nema *(First, Middle, Maiden Sumema)*: Pauline Schmidt

19a. Informent's Name/Reletionship *(Type, Print)*: Thomas Fioretti/Son
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 6912 Keats Court, Rockville, Maryland 20855

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removel from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Nema of cemetery, cremetory or other piece)*: Metropolitan Crematory
Date: 1/18/01
20c. Location - City or Town, Steta: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Michael Welch
22. Nama end Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused the daath. Do not enter the moda of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immediate Ceuse (Finel disaase or condition resulting in death):
a. PNEUMONIA — 24 HOURS

Due to (or es e consequence of):
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 25 YEARS

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last

Due to (or es a consequance of):
c. BRONCHIECTASIS — 25 YEARS

Due to (or as a consequenca of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminar? 1☐ Yes 2☑ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date end pleca, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: Paul T. Wielebinski
29c. License number: D33719
29d. Dete signed *(Month, Day, Year)*: JANUARY 17, 2001

30. Name and eddress of parson who completed cause of death (Item 23a) (Type, Print): PAUL T. WIELEBINSKI, MD 18550 OFFICE Park Drive, GAITHERSBURG, MARYLAND 20886

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CPS
01-0352-031
HEUNGSOO SIM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03446

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Heung Soo Sim
2. Date of Death Month Day Year: January 20, 2001
3. Time of Death: 20:35
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 152-02-8199
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 20 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 24, 1980
9. Birthplace (State or Foreign Country): Korea

Usual Residence of Decedent

10a. State: New Jersey
10b. County: Bergen
10c. City, Town or Location: Ridgewood
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 144 South Maple Avenue, #B-6
10f. Zip Code: 07450
10g. Citizen of What Country?: Korea

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: College

17. Father's Name (First, Middle, Last): Yoon K. Sim
18. Mother's Name (First, Middle, Maiden Surname): Kyung H. Hwang

19a. Informant's Name/Relationship (Type, Print): Kyung H. Lee / Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 144 South Maple Ave., #B-6, Ridgewood, NJ 07450

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedarlawn Crematory
Date: 01/26/01
20c. Location - City or Town, State: Paterson, New Jersey

21. Signature of Funeral Service Licensee: James J. Chrisman
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): 1/20/01
28b. Time of Injury: 1635 M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: Driver of Motor Vehicle Impacts Fixed Objects and Overturns
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street
28f. Location (Street and Number or Rural Route Number, City or Town, State): Frederick County, Maryland

29a. Certifier (Check only one): 1☐**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Pestaner, M.D.
29c. License number: OCME
29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signature: Bernice G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03447

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Lee Sigler SR.

2. Date of Death: Month January Day 12 Year 2001

3. Time of Death: 7:50 PM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-28-8325

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): Mar. 4, 1933

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: Frederick

10c. City, Town or Location: Middletown

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 6630 Mt. Church Rd.

10f. Zip Code: 21769

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1953-1956

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): parts inspector

16b. Kind of Business/Industry: electric motors

17. Father's Name (First, Middle, Last): Mehrl J. Sigler

18. Mother's Name (First, Middle, Maiden Surname): Catherine Jones

19a. Informant's Name/Relationship (Type, Print): Fern E. Sigler (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6630 Mt. Church Rd., Middletown, MD. 21769

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Locust Valley Cemetery

Date: 1/16

20c. Location - City or Town, State: Middletown, MD.

21. Signature of Funeral Service Licensee: Donald B. Thompson

22. Name and Address of Facility: Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Middle cerebral artery cerebrovascular accident — 3 days

Due to (or as a consequence of):

b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hyperlipidemia

Due to (or as a consequence of):

d. Diabetes mellitus

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

atherosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: 037178

29d. Date signed (Month, Day, Year): January 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher Fleming, M.D. 610 Ninth Avenue Brunswick, MD 21716

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: Denise D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03448

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Preston Shelly

2. Date of Death (Month, Day, Year): Jan. 19, 2001

3. Time of Death: 11:55 AM.

4a. Facility Name *(If not institution, give street and number)*: Crofton Convalescent Center

4b. City, Town, or Location of Death: Crofton

4c. County of Death: Anne Arundle

Funeral Director

5. Social Security Number: 577-10-0807

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 17, 1904

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: D.C.

10b. County:

10c. City, Town or Location: Washington, D.C.

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4000 Cathedral Ave. NW. #207B

10f. Zip Code: 20016

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Musician

16b. Kind of Business/Industry: Music

17. Father's Name *(First, Middle, Last)*: Preston Shelly, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Jane Stickney

19a. Informant's Name/Relationship *(Type, Print)*: Thomas S. Wolking - Nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 911 Annapolis Road, Gambrills, Md. 21054

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: National Crematory

Date: 1/23/01

20c. Location - City or Town, State: Falls Church, Va.

21. Signature of Funeral Service Licensee: Thomas Hombaker

22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. End Stage Alzheimer's Disease — 10 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul S Rhoades MD

29c. License number: D22028

29d. Date signed *(Month, Day, Year)*: January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul S. Rhoades, MD. 1667 Crofton Center, Crofton, Md. 21114-1303

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: Pamela G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03449

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MERWIN NELSON SEYBOLT
2. Date of Death (Month, Day, Year): JANUARY 19, 2001
3. Time of Death: 12:25 PM
4a. Facility Name (If not institution, give street and number): SHARON NURSING HOME
4b. City, Town, or Location of Death: SANDY SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 339 24 7996
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 22, 1911
9. Birthplace (State or Foreign Country): NEBRASKA

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: OLNEY
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4201 QUEEN MARY DRIVE
10f. Zip Code: 20832
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ACCOUNTANT
16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Father's Name (First, Middle, Last): JAMES M. SEYBOLT
18. Mother's Name (First, Middle, Maiden Surname): CLARE NELSON

19a. Informant's Name/Relationship (Type, Print): ANTOINETTE SEYBOLT, WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4201 QUEEN MARY DRIVE, OLNEY, MD. 20832

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY
Date: 1/22/01
20c. Location - City or Town, State: SILVER SPRING, MD.

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber
22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA — 11 DAYS
Due to (or as a consequence of):
b. DYSPHAGIA — 12 DAYS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. CEREBROVASCULAR ACCIDENT — 12 DAYS
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: VASCULAR DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
26e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
26d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ ATTENDING PHYSICIAN
29c. License number: D42046
29d. Date signed (Month, Day, Year): January 19, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 20860

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amend #26 1/24/2001, BMW, Montg. Co.

Reg. No. 2001 03450

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vann E. Savage

2. Date of Death (Month, Day, Year): January 22, 2001

3. Time of Death: 10:30 AM

4a. Facility Name (If not institution, give street and number): 3308 Buehler Court

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 230-01-3539

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 14 1921

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Olney

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 3308 Buehler Court

10f. Zip Code: 20832

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Naval Officer

16b. Kind of Business/Industry: United States Navy

17. Father's Name (First, Middle, Last): George Bruce Savage

18. Mother's Name (First, Middle, Maiden Surname): Eula Floy Eakins

19a. Informant's Name/Relationship (Type, Print): Paula V. Savage / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3308 Buehler Court, Olney, Maryland 20832

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 1/23/01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Muriel H. Barber

22. Name and Address of Facility: Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Maryland 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial Infarction	Acute
Due to (or as a consequence of): b.	Coronary Artery Disease	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Respiratory Failure	1 Year
Due to (or as a consequence of): d.	Chronic Obstructive Pulmonary Disease	Years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Peripheral Vascular Disease

Congestive Heart Failure, Pacemaker

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient ~~2 [ ] ER/Outpatient~~ 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Saulius Naujokaitis M.D.

29c. License number: DC13091

29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Saulius Naujokaitis, M.D. 3301 New Mexico Ave., N.W. Suite 349 Washington, DC 20016

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

35+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03451

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julian Sambataro
2. Date of Death (Month, Day, Year): January 24, 2001
3. Time of Death: 12:25PM
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-20-2324
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Nov 21, 1923
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Burtonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4204 Dustin Road
10f. Zip Code: 20866
10g. Citizen of What Country?: USA

11. Merital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired): Insurance Broker
16b. Kind of Business/Industry: Self Employed

17. Father's Neme (First, Middle, Last): Anthony Sambataro
18. Mother's Name (First, Middle, Meiden Surneme): Mary DelVecchio

19a. Informant's Name/Ralationship (Type, Print): Dolores L. Sambataro/ Wife
19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code): 4204 Dustin Road, Burtonsville, MD 20866

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Gate of Heaven Cemetery
Date: Jan 27 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funerel Service Licensee: Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)
a. Cardiac Arrest — less than 1 1/2 hrs
Due to (or as a consequence of):
b. Acute Myocardial Infarction — minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or es e consequence of):
c. Coronary Artery Disease — years
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mannar of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending Investigetion 6☐ Could not be detarmined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To tha best of my knowledge, death occurred at the tima, data and place, and due to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to tha cause(s) and mennar stated.

29b. Signature and title of certifier: Henry S. Willner, MD
29c. License number: D25137
29d. Date signed (Month, Day, Year): 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Henry S. Willner, MD 7300 Van Dusen Road Laurel, MD 20707

State Registrar

31. Dete filed (Month, Dey, Year): JAN 26 2001
32. Registrer's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03452

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Beatrice E. Tobias

2. Data of Death — Month: January; Day: 14; Year: 2001

3. Time of Death: 8:13 A. M.

4a. Facility Name (If not institution, give street and number): Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 051-14-1264

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 30, 1913

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3700 International Drive

10f. Zip Code: 20906

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elamentary/Secondary (0-12): ; Collaga (1-4or 5+): 4 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edward DalNegro

18. Mother's Name (First, Middle, Maiden Surname): Lillie Sussman

19a. Informant's Name/Relationship (Type, Print): Edward L. Tobias - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7408 Bee Bee Drive, Derwood, Maryland 20855

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Metropolitan Crematory

Date: 1/17/2001

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer

22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Intervet Between Onsat and Death

Immediate Cause (Finel disease or condition resulting in daath)

a. RESPIRTTORY FAILURE — WKS

Due to (or as a consequence of):

b. HYPERCARBIA — WKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

Due to (or as a consequenca of):

c. END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE — YRS

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, DEPRESSION, SPINAL STENOSIS, PRIOR COLOVESICULAR FISTULA

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Steven Tilair — MD

29c. License number: D36252

29d. Date signed (Month, Dey, Year): JANUARY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN T. KARIYA, MD, 11501 GEORGIA AVE. #515, WHEATON MD 20902

State Registrar

31. Data filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: ▶ Linda G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.** 6

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03453

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Burlock Charles Thompson

2. Date of Death Month / Day / Year: January 20, 2001

3. Time of Death: 4:00 P.M.

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 156-10-5456

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 22, 1916

9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5420 Moorland Lane

10f. Zip Code: 20814

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12); College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Energy Economist

16b. Kind of Business/Industry: Department of Energy

17. Father's Name *(First, Middle, Last)*: John Charles Thompson

18. Mother's Nema *(First, Middle, Maiden Surname)*: Irene Burlock

19a. Informant's Name/Relationship *(Type, Print)*: Kathryn Amidon/Daughter

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 5420 Moorland Lane, Bethesda, Maryland 20814

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from Stete 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Norbeck Memorial Park

Dete: Jan. 24, 2001

20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in deeth)

a. PNEUMONIA

Due to (or es a consequence of):

Sequentially list conditions, if sny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE, RENAL FAILURE, DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner ss stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete snd place, snd due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D26571

29d. Date signed *(Month, Day, Year)*: 1/22/01

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print): IRVING MIZUS, MD 4930 DEL RAY AVE BETHESDA, MD 20814

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Burlock Thompson 1-20-01 4:00 pm

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03454

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES BLAIR THOMAS II

2. Date of Death: Month JANUARY Day 6, Year 2001

3. Time of Death: 3:40 AM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 202-38-9334

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sep 22, 1947

9. Birthplace (State or Foreign Country): Windber, PA

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Middletown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 8600 Wiles Court

10f. Zip Code: 21769

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 68-72

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Electrical Power

17. Father's Name (First, Middle, Last): James B. Thomas I

18. Mother's Name (First, Middle, Maiden Surname): Betty Hutchinson

19a. Informant's Name/Relationship (Type, Print): Margaret A. Thomas - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8600 Wiles Court MIddletown, MD 21769

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Richland Cemetery

Date: 1-10-01

20c. Location - City or Town, State: Johnstown, PA

21. Signature of Funeral Service Licensee: Allen F. Woodall

22. Name and Address of Facility: Metropolitan Funeral Service 5517 Vine St. Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Hypoglycemia	Hour
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Septicemia-Enterococcus	Week
Due to (or as a consequence of):		
c.	Infected Dialysis Catheter	Week
Due to (or as a consequence of):		
d.	Renal Failure	Months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cirrhosis - Probably Alcoholic or Cryptogenic in Nature

End Stage Renal Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D47556

29d. Date signed (Month, Day, Year): 1-7-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM H. JOHNSON MD 172 THOMAS JOHNSON DR. FREDERICK, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03455

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BART TEGELER
2. Date of Death (Month, Day, Year): January 18, 2001
3. Time of Death: 8:52AM
4a. Facility Name (If not institution, give street and number): 2408 Mistletoe Place
4b. City, Town, or Location of Death: Adelphi
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 217-70-7885
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 32 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 21, 1968
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Adelphi
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2408 Mistletoe Place
10f. Zip Code: 20783
10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 18 yrs. Spec. Ed.
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): None
16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Charles Tegeler
18. Mother's Name (First, Middle, Maiden Surname): Patricia Newman

19a. Informant's Name/Relationship (Type, Print): Patricia Tegeler / Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2408 Mistletoe Place, Adelphi, Maryland 20783

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 01/20/01
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEIZURE

Due to (or as a consequence of):
b. SEIZURE DISORDER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CEREBRAL PALSY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D 25914
29d. Date signed (Month, Day, Year): 1/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALLEN BRIMMER, M.D. 2201 PLUM ORCHARD DR. SILVER SPRING, MD 20904

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: ▶ Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03456

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Emma Reback Voron	January 22, 2001	3:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Hebrew Home of Greater Washington	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-44-9770	1☐ M 2☒ F	92 Yrs.			Feb. 24, 1908	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14137 Flint Rock Rd.	20853	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Michael Reback	Kate Novick

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara M. Schiller/Daughter	14137 Flint Rock Rd. Rockville, MD. 20853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	King David Memorial Gards.	1/24/01	Falls Church, VA.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike. Rockville, MD. 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. CEREBRAL THROMBOSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CEREBRAL ATHEROSCLEROSIS

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MULTI-INFARCT DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	D18084	JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
D.D. PATEL M.D. 6121 MONTROSE RD, ROCKVILLE MD 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 25 2001	▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03457

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Anna VonEssen
2. Date of Death (Month, Day, Year): January 19, 2001
3. Time of Death: 8:10am
4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-60-3462
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 10, 1922
9. Birthplace *(State or Foreign Country)*: Iowa

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 19931 Dunstable Circle
10f. Zip Code: 20876
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1944-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Registered Nurse
16b. Kind of Business/Industry: Nursing

17. Father's Name *(First, Middle, Last)*: Frank Sabus
18. Mother's Name *(First, Middle, Maiden Surname)*: Cecelia Connor

19a. Informant's Name/Relationship *(Type, Print)*: Arthur VonEssen (Husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 19931 Dunstable Circle, Germantown, MD 20876

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cramatory or other place)*: Arlington National Cem.
Date: 1/26/2001
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Robert H. DeVol
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Renal Failure	1 Week
Due to (or as a consequence of):	b. Multiple Myeloma	1 Year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive & Arteriosclerotic Cardiovascular Disease

Insulin Dependent Diabetes Mellitus w/ Diabetic

Nephropathy & Peripheral Neuropathy

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James A. Brown MD
29c. Licansa number: D07285
29d. Date signed *(Month, Day, Year)*: January22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James A. Brown, MD 9707 Medical Center Drive, Rockville, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001
32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03458

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George Herman Vergine
2. Date of Death Month Day Year: January 15, 2001
3. Time of Death: 8:53 am
4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 311-05-5207
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov 4, 1914
9. Birthplace *(State or Foreign Country)*: Indiana

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 15107 Interlachen Drive # 912
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Analyst
16b. Kind of Business/Industry: National Security Administration

17. Father's Name *(First, Middle, Last)*: Herman Carl Vergine
18. Mother's Name *(First, Middle, Maiden Surname)*: Tilda Bertha Peters

19a. Informant's Name/Relationship *(Type, Print)*: Clara Vergine / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15107 Interlachen Drive #912, Silver Spring, MD 20906

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: Jan 18 2001
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Edema
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD.
29c. License number: D500612
29d. Date signed *(Month, Day, Year)*: January 15, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Samuel Maller, MD 3305 N. Leisure World Blvd., Silver Spring, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03459

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DARYLE W. WILLETT
2. Date of Death (Month, Day, Year): JAN. 20, 2001
3. Time of Death: 4:15 AM
4e. Facility Name (If not Institution, give street and number): WASHINGTON ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 213-86-5479
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 40 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 25, 1960
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10e. State: MD.
10b. County: PRINCE GEORGES
10c. City, Town or Location: HYATTSVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1516 CHILLUM RD. #4
10f. Zip Code: 20782
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): LIONEL WILLETT
18. Mother's Name (First, Middle, Maiden Surname): JONE ALICE MOSTELLER

19a. Informant's Name/Relationship (Type, Print): STEVEN BULLOCK/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1306 MAPLE ST., SHADYSIDE, MD. 20764

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): CHAMBERS CREMATORY
Date: 1/24/01
20c. Location - City or Town, State: RIVERDALE, MD.

21. Signeture of Funeral Servica Licensee: W.W. Chambers MO0091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., 5801 CLEVELAND AVE. RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. CARDIOPULMONARY ARREST

Due to (or as a consequence of):
b. ADVANCED ACQUIRED IMMUNODEFICIENCY SYNDROME

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Onyeka MD
29c. License number: D46529
29d. Date signed (Month, Day, Year): JANUARY 20 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VICTOR ONYEGIAKA 7325A HANOVER PARKWAY GREENBELT MARYLAND

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03460

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melvin Wright
2. Date of Death (Month, Day, Year): January 23, 2001
3. Time of Death: 10:25 AM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 577-48-0166
6. Sex: 1☐ M 2☐ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 28, 1905
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9901 Big Rock Road
10f. Zip Code: 20904
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Decorator/Painter
16b. Kind of Business/Industry: Home Decorating

17. Father's Name (First, Middle, Last): Joseph Oscar Wright
18. Mother's Name (First, Middle, Maiden Surname): Julia Balthis Offenbacker

19a. Informent's Name/Relationship (Type, Print): Diane Harper (Step Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6800 Fleetwood Road, Apt. 1013, McLean, VA 22101

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory
Date: 1/24/01
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr.
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA — 30 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George I. Smith, M.D. VPMA
29c. License number: D10587
29d. Date signed (Month, Day, Year): 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE I. SMITH, M.D. VICE-PRES MED AFFAIRS FREDERICK MEMORIAL HOSPITAL FREDERICK, MD. 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#1 per MD 01/29/2001 FCHD

Certificate of Death

Reg. No. 2001 03461

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~WEEDON, ELSIE~~ Elsie Weedon

2. Date of Death (Month, Day, Year): JAN. 8, 2001

3. Time of Death: 9:30 pm

4a. Facility Name (If not institution, give street and number): 410 B CENTER ST.

4b. City, Town, or Location of Death: FREDERICK, MD

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 213-40-6632

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 7, 1940

9. Birthplace (State or Foreign Country): md.

Usual Residence of Decedent

10a. State: md.

10b. County: FREDERICK

10c. City, Town or Location: FREDERICK

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 410 B CENTER ST.

10f. Zip Code: 21701

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): RAYMOND ELLIS SCOTT

18. Mother's Name (First, Middle, Maiden Surname): CARRIE JACKSON

19a. Informant's Name/Relationship (Type, Print): DAVID A. WEEDON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 410 B CENTER ST FREDERICK MD 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fairview Cem. Date: JAN. 15, 2001

20c. Location - City or Town, State: Fred MD.

21. Signature of Funeral Service Licensee: Gary L. Rollins

22. Name and Address of Facility: GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST FREDERICK MD, 21701

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. UNDIFFERENTIATED CARCINOMA, SKULL BASE — 5 1/2 YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

N/A

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: CHRISTOPHER K. SINHA, M.D.

29c. License number: D0054929

29d. Date signed (Month, Day, Year): JAN. 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTOPHER K. SINHA M.D 3416 OLAND WOOD CT. SUITE 207 OLNEY, MD 20832

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Brenda B Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03462

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Haddaway Warfield

2. Date of Death Month Day Year: January 16, 2001

3. Time of Death: 9:30 AM

4a Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-14-1642

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 8,1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5663 Crabapple Drive

10f. Zip Code: 21703

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Reca - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Land Appraiser

16b. Kind of Business/Industry: Federal Government

17. Father's Neme (First, Middle, Last): E. Watkins Warfield

18. Mother's Name (First, Middle, Maiden Surneme): Emma Driver

19a. Informent's Neme/Reietionship (Type, Print): Terrance W. Warfield/ Son

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1613 Rock Creek Drive, Frederick, Maryland 21702

20a. Method ot Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Damascus U. M. Cemetery

Dete: 1/20/2001

20c. Location - City or Town, Steta: Damascus, Maryland

21. Signature of Funerel Service Licensee: Todd Olmsworth

22. Name end Address of Facility: Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in deeth)

a. Congestive heart failure — 3 wks

Due to (or es a consequenca of):

b. Coronary artery disease — years

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Last

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end placa, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: Todd Olmsworth

29c. License number: D 27109

29d. Dete signed (Month, Day, Year): 1/17/01

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Lloyd Halvorson MD, 1475 Taney Ave, Frederick Md

State Registrar

31. Date filed (Month, Dey, Year): JAN 18 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 03463

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Beatrice Lillian Wedge

2. Date of Death — Month: January; Day: 18; Year: 2001

3. Time of Death: 6:20 a.m.

4a. Facility Name *(If not institution, give street end number)*: Northampton Manor Nursing Home

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick County

Funeral Director

5. Social Security Number: 217-18-7331

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 13, 1924

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 48 Carver Apartments, Madison Street

10f. Zip Code: 21701

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: self

16b. Kind of Business/Industry: homemaker

17. Father's Neme *(First, Middle, Last)*: John Bowens

18. Mother's Name *(First, Middle, Maiden Surname)*: Cleaslea Keyes

19a. Informant's Neme/Relationship *(Type, Print)*: Josephine Beander, daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: PO Box 117, Point of Rocks, Maryland, 21777

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Fairview Cemetery

Date: 1/24/2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: [signature] M00999

22. Name end Address of Facility: Keeney and Basford Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in deeth)

a. ACUTE RESPIRATORY FAILURE — <24hours

Due to (or es a consequence of):

b. C.O.P.D. — YEARS

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. Other alginificant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

CONGESTIVE HEART FAILURE

MORBID OBESITY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D32171

29d. Date signed *(Month, Day, Year)*: 1/18/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): RICHARD L. GOUGH 191 W FREDERICK ST WALKERSVILLE MD 21793

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signeture: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit pmit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03464

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES NELSON WEADON
2. Date of Death Month: JANUARY Day: 18, Year: 2001
3. Time of Death: 1:23 AM
4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 557-12-7883
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 24, 1914
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 30 North Place
10f. Zip Code: 21701
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: unknown
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Brankeman
16b. Kind of Business/Industry: Railroad

17. Father's Neme *(First, Middle, Last)*: unknown
18. Mother's Name *(First, Middle, Maiden Sumeme)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: Carolyn True, guardian
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: Department of Aging of Frederick County Citizens Services Bldg. 520 N. Market St., Frederick, MD 21701

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Smithsburg Crematory — Date: 1/23/2001
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Berger — MO0999
22. Name and Address of Facility: Keeney and Basford Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death) a.	ASYSTOLE	40 MIN.
Due to (or as a consequence of): b.	ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	UNKNOWN
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or es e consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: ORGANIC BRAIN SYNDROME WITH DEMENTIA; CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Geo. I. Smith, M.D. VAMA
29c. License number: D10587
29d. Date signed *(Month, Day, Year)*: 1/19/2001

30. Neme and address of person who completed ceuse of death (Item 23e) (Type, Print): GEORGE I. SMITH, M.D.; VICE-PRES. MED. AFFAIRS FREDERICK MEMORIAL HOSP. FREDERICK, MD. 21701

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03465

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Simpson Whitten
2. Date of Death (Month, Day, Year): January 20, 2001
3. Time of Death: 2:00 PM
4a. Facility Name (If not institution, give street and number): Crofton Convalescent Center
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 425-36-3829
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 10, 1926
9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Crofton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2131 Davidsonville Road
10f. Zip Code: 21114
10g. Citizen of What Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Clothing Manufacturer

17. Fether's Neme (First, Middle, Last): Louis Jefferson Simpson
18. Mother's Name (First, Middle, Maiden Surname): Sarah W. Duncan

19a. Informent's Neme/Reletionship (Type, Print): Dan Whitten - son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2011 Willow Glen Court, Crofton, MD 21114

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Friendship Cemetery
Dete: Jan. 25, 2001
20c. Location - City or Town, Stete: Columbus, MS

21. Signeture of Funerel Service Licensee: Daniel A. Cuttino
22. Neme end Address of Fecility: Metropolitan Funeral Service 5517 Vine St. Alexandria, VA 22310

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

GF

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death): a. Chronic Obstructive Lung Disease — 5 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
26d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the bast of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: Andrew S. Dobin
29c. License number: D34405
29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew S. Dobin, M.D. 4175 N. Hanson Ct. Suite 203 A Bowie, MD

State Registrar

31. Dete filed (Month, Day, Year): JAN 25 2001
32. Registrar's Signeture: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03466

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Whitmore

2. Date of Death: Month: JAN Day: 22 Year: 2001

3. Time of Death: 09:37 am

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia, MD

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 493-64-3034

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last Birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 23, 1904

9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Highland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14065 Route 108

10f. Zip Code: 20777

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Claude McClur Gray

18. Mother's Name (First, Middle, Maiden Surname): Charlotte Head

19a. Informant's Name/Relationship (Type, Print): John Whitmore / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7373 Tilghman Island Rd., Sherwood, MD 21665

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory | Date: 01/23/01

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: ▶ Alan J. Donnell

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. respiratory failure — hours

Due to (or as a consequence of):
b. respiratory infection — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

advanced age

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D-53636

29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. Bishoff Carlson, MD 3460 Ellicott Center Drive, Ellicott City MD 21043

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001

32. Registrar's Signature: ▶ Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

G.F.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#9 per inf G794 041801 SS
AMENDED# 8,17,18 per inf G793 031301 SS

Certificate of Death

Reg. No. 2001 03467

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARTHA ROSA WELCH

2. Date of Death Month Day Year: 01/16/2001

3. Time of Death: 5:00 PM

4a. Facility Name (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death: MARYLAND

4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 577-44-2417

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 98 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~08/1/1902~~ 08/1/1902

9. Birthplace (State or Foreign Country): ~~MARYLAND~~ Long Island, NY

Usual Residence of Decedent

10a. State: MD.

10b. County: P.G.

10c. City, Town or Location: MARYLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5014 WHEELER RD.

10f. Zip Code: 20745

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: NONE

17. Father's Name (First, Middle, Last): ~~ERNEST BEHRENS~~ ERNEST L. BEHRENS

18. Mother's Name (First, Middle, Maiden Surname): ~~JULIA GRASKEPH~~ JULIA SOPHIA GRASSKOPH

19a. Informant's Name/Relationship (Type, Print): JACK WELCH / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7946 Mc LAREN AVE. CANOGA PARK CALIFORNIA

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from Stete 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GEORGETOWN MEDICAL

Date: 01/16/01

20c. Location - City or Town, State: WASHINGTON D.C.

21. Signature of Funeral Service Licensee: Terry O. Austin

22. Name and Address of Facility: AUSTIN ROYSTER FUNERAL HOME 3821 14th ST. N.W. WASH. D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ATHEROSCLEROTIC CORONARY VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: [signature]

29c. License number: D19431

29d. Date signed (Month, Day, Year): 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frank M. Taylor M.D. 11701 Livingston Rd #203 Ft. Washington MD 20744

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03468

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Judyta Weiss
2. Date of Death (Month, Day, Year): January 17, 2001
3. Time of Death: 2:30 PM
4a. Facility Name (If not institution, give street and number): Hebrew Home of Greater Washington
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 059-28-9059
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 3, 1917
9. Birthplace (State or Foreign Country): Poland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6121 Montrose Road
10f. Zip Code: 20852
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laboratory Assistant
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Abraham Truskier
18. Mother's Name (First, Middle, Maiden Surname): Rachela Heinsdorf

19a. Informant's Name/Relationship (Type, Print): Paula Cohen/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9377 Bremerton Way, Montgomery Village, MD 20886

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Beth Abraham Jacob Cemetery — Date: 1/19/2001
20c. Location - City or Town, State: Guilderland, NY

21. Signature of Funeral Service Licensee: Dennis Gittins
22. Name and Address of Facility: Metropolitan Funeral Service, Inc. 5517 Vine Street, Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. MITRAL VALVE REGURGITATION
Due to (or as a consequence of):
b. CALCIFIC MITRAL VALVE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ATHEROSCLEROSIS
HYPERTENSION, ESSENTIAL

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M Patel M.D.
29c. License number: D18084
29d. Date signed (Month, Day, Year): JANUARY 17, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03469

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN C. WEBSTER

2. Date of Death — Month: JANUARY Day: 19 Year: 2001

3. Time of Death: 7:17 PM

4a. Facility Name (If not institution, give street and number): Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-16-3510

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 1, 1922

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 20921 Zion Road

10f. Zip Code: 20882

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 43-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 7th — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Animal Keeper

16b. Kind of Business/Industry: Naval Med. Center

17. Father's Name (First, Middle, Last): Louis Webster

18. Mother's Name (First, Middle, Maiden Surname): Maude Swailes

19a. Informant's Name/Relationship (Type, Print): Alice V. Webster (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20921 Zion Rd., Gaithersburg, MD 20882

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Md. Veterans Cem.

Date: 1/25/01

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service License: George R. Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Acute Myocardial Infarction	1 hour
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — b.	Diabetes Mellitus	10 years
Due to (or as a consequence of):		
c.	1	
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 14057

29d. Date signed (Month, Day, Year): January 20, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Lewis Kellert, M.D. 4000 Olney Laytonsville Rd. Olney, Md. 20832

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03170

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward C. Wallington, Jr.
2. Date of Death Month Day Year: January 24, 2001
3. Time of Death: 10:49 am
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-28-5259
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 23, 1921
9. Birthplace (State or Foreign Country): Washington

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11203 Mitscher Street
10f. Zip Code: 20895
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Certified Public Accountant
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Edward C. Wallington
18. Mother's Name (First, Middle, Maiden Surname): Fanny Taylor

19a. Informant's Name/Relationship (Type, Print): Eugenia H. Wallington/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11203 Mitscher Street, Kensington, MD 20895

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Church of the Ascension — Date: Jan 27 2001
20c. Location - City or Town, State: Bowie , MD

21. Signature of Funeral Service Licensee: Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory Arrest
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Diffuse Lung Damage
Due to (or as a consequence of):
c. Interstitial Lung Disease
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chun-Ming Tseng MD
29c. License number: D52043
29d. Date signed (Month, Day, Year): 1/24/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Chun-Ming Tseng MD 1221 Mercantile Lane, Largo, MD 20774

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: Donna D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1-VR
10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03171

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Waldon

2. Date of Death Month: January Day: 16 Year: 2001

3. Time of Death: 1:45 am

4a Facility Name (If not institution, give street end number): Mariner Health - Circle Manor

4b. City, Town, or Location of Death: Kensington

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-32-2099

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 4, 1911

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10231 Carroll Place

10f. Zip Code: 20895

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12

College (1-4or 5+):

18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): William Tracy

18. Mother's Name (First, Middle, Maiden Surneme): Rebecca UNKNOWN

19a. Informent's Neme/Reletionship (Type, Print): James A. Waldon (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 10231 Carroll Place Kensington, Maryland 20895

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Maryland National Memorial Park

Date: Jan 22 2001

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funerel Service Licensee: Jeanne Marie Parker

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in death)

a. Cerebrovascular Accident — 1 day

Due to (or es a consequence of):

Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Lest

b.

Due to (or as e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contributa to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was case referred to medicel exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of *my* knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in *my* opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier

29c. License number: D53528

29d. Date signed (Month, Day, Year): January 16,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daphne Henkin, M.D., 2309 Shorefield Rd.,Wheaton,Maryland 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signeture: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03472

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kaden Yohai

2. Date of Death (Month, Dey, Year): January 20, 2001

3. Time of Death: 10:15 PM

4a. Facility Name *(If not institution, give street and number)*: Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 124-12-5864

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov 5, 1919

9. Birthplace *(State or Foreign Country)*: NY

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1 Dundee Ct.

10f. Zip Code: 20850

10g. Citizen of What Country?: United States

11. Meritel Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Frank Calumet

18. Mother's Name *(First, Middle, Maiden Surname)*: Esther (unk)

19e. Informent's Neme/Reletionship *(Type, Print)*: Paul Yohai /Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1 Dundee Ct., Rockville, MD 20850

20e. Method of Disposition: 1☐Burial 2☒Cremetion 3☐Removel from State 4☐Donetion 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Date: Jan 26 2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Beverly L Herlitt

22. Name and Address of Facility: Rapp Funeral Home & Cremation Services 933 Gist Ave. Silver Spring, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final diseese or condition resulting in death)

e. METASTATIC COLON CANCER

Due to (or as a consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Wes en autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medicat exeminer? 1☐Yes 2☑No

26. Place of Death *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☑Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner ss stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner steted.

29b. Signeture and title of certifier: Gregory A Compton MD

29c. License number: D24942

29d. Date signed *(Month, Day, Year)*: JAN 22 2001

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): GREGORY A. COMPTON MD 6121 Montrose Rd Rockville, MD

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03473

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Selma Yesley
2. Date of Death Month Day Year: January 21, 2001
3. Time of Death: 8:55 AM
4a. Facility Name *(If not institution, give street and number)*: Manor Care of Chevy Chase
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 010-36-6897
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec 22, 1912
9. Birthplace *(State or Foreign Country)*: NY

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 8700 Jones Mill Rd.
10f. Zip Code: 20815
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4 or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Joseph Muroff
18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Korenman

19a. Informant's Name/Relationship *(Type, Print)*: Joel Yesley /Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11604 Lakewater Lane, Columbia, MD 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Sharon Memorial CEMETERY
Date: Jan 23 2001
20c. Location - City or Town, State: Randolph, MA

21. Signature of Funeral Service Licensee: ▶ Beverly L. Helmstetter
22. Name and Address of Facility: Rapp Funeral Home & Cremation Services 933 Gist Ave. Silver Spring, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Inanition	3 months
Due to (or as a consequence of):		
b.	Malnutrition Dehydration	3 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.	Dysplasia	3 months
Due to (or as a consequence of): d.	Parkinson Disease	2 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)* / 28b. Time of Injury M / 28c. Injury at Work? 1☐ Yes 2☐ No / 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* / 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ James J. Foster MD
29c. License number: D04179
29d. Date signed *(Month, Day, Year)*: 1/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James J. Foster 5330 Wise Ave Chevy Chase Md 20815

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 03174

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Yao Fong Yee

2. Date of Death (Month, Day, Year): January 18, 2001

3. Time of Death: 2:40 am

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-38-6660

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 11, 1911

9. Birthplace (State or Foreign Country): China

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7333 17th Avenue

10f. Zip Code: 20783

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Unkonown Fong

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informent's Neme/Relationship (Type, Print): Cheng Y. Yee / Son

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12340 Loft Lane, Silver Spring, MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cemetery

Date: Jan 21 2001

20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: James S Dooley

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finet diseese or condition resulting tn death)

a. Respiratory failure

Due to (or as a consequence of):

b. Brain Herniation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

c. Brain swelling

Due to (or as a consequence of):

d. Massive stroke

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

previous stroke

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rashid Nayhai Naini M.D.

29c. License number: D 39372

29d. Date signed (Month, Day, Year): January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RASHID NAYHAI-NAINI 300 University Blvd Suit 324 Silver Spring MD 20901

State Registrar

31. Dete filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03475

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PAULINE IDA ZUMBRUM
2. Date of Death (Month, Day, Year): JANUARY 23, 2001
3. Time of Death: 6:40 PM
4a. Facility Name *(If not institution, give street and number)*: 8220 HEDGE APPLE WAY
4b. City, Town, or Location of Death: GAITHERSBURG
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 176-05-3782
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Jan 17, 1914
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedant

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 8220 Hedge Apple Way
10f. Zip Coda: 20879
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yaa or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* White
15. Decedant's Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12): 8 — Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Housewife
16b. Kind of Business/Industry: Own Home
17. Fathar's Nama *(First, Middla, Last)*: John Bankert
18. Mothar's Name *(First, Middla, Maiden Surnama)*: Della Wilison
19a. Informant's Name/Raiationship *(Type, Print)*: Barbara Zumbrum, Daughter
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 8220 Hedge Apple Way, Gaithersburg, MD 20879
20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar placa)*: St. Paul United Church of Christ Cem — Data: 1/27 2001
20c. Location - City or Town, Stata: Hanover, PA
21. Signatura of Funaral Service Licensee: ▶ Curtis E. Day
22. Nama and Address of Facility: DEVOL FUNERAL HOME 10 E. DEER PARK DRIVE, GAITHERSBURG, MD 20877

Physician /Medical Examiner

23a. Part1. Entar tha disasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, ahock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Batwaen Onset and Death

Immediata Ceusa (Final disaasa or condition resulting in death):
a. FACIAL CANCER — 2 YEARS
Dua to (or as a consaquance of):
Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknow

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of causa ot death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☒ Residence 6☐ Othar *(Specify)*

27. Manner of Daath: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and due to tha ceuse(s) and mannar stetad.

29b. Signatura and titia of certifier: ▶ James Michael Anchors MD
29c. Licansa number: D29730
29d. Data signed *(Month, Day, Year)*: JANUARY 24, 2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): JAMES MICHAEL ANCHORS, M.D., 16220 FREDERICK ROAD, #210 GAITHERSBURG, MD 20877

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signatura: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03476

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dr. Morris L. Ziskind
2. Date of Death Month Day Year: January 22, 2001
3. Time of Death: 10:55am
4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 157-30-7450
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 24, 1914
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedant

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3710 International Drive, Apt. 346
10f. Zip Code: 20906
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4 Years
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Veterinarian
16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: Samuel Ziskind
18. Mother's Name *(First, Middle, Maiden Sumama)*: Jennie Rabinowicz

19a. Informant's Name/Relationship *(Type, Print)*: Jerome A. Ziskind - Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 509 North West Street, Falls Church, Virginia 22046

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Judean Memorial Gardens
Date: 1/25/2001
20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funaral Service Licensee: ▶ Donald C. Stottlemyer
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Intarval Batween Onset and Death

Immediate Ceuse (Final disaase or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):
b. Congestive Heart Failure
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events rasulting in daath) Last
Due to (or as a consequanca of):
c. Severe Dilated Cardiomyopathy
Due to (or as a consequanca of):
d.

Part II. Other **significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.
29b. Signatura and title of cartifier: ▶ Wilkinson J. Ninala
29c. Licensa number: D 45285
29d. Data signad *(Month, Day, Year)*: January 23, 2001
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): W J. Ninala, 344 University Blvd, #113, Silverspring, Md

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001
32. Registrar's Signature: ▶ Bernice B. Stokes

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(12)2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03477

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Casimir J. Ziolkowski

2. Date of Death Month Day Year: January 16, 2001

3. Time of Death: 8:30 a.m.

4a. Facility Name *(If not institution, give street and number)*: Manor Care Nursing Home

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 391-01-4622

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 3, 1910

9. Birthplace *(State or Foreign Country)*: Wisconsin

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5606 Roosevelt Street

10f. Zip Code: 20817

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Defea: WWII

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Servant

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Joseph Ziolkowski

18. Mother's Name *(First, Middle, Maiden Surname)*: Victoria Grelevich

19a. Informant's Name/Relationship *(Type, Print)*: Helen Ziolkowski/ Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5606 Roosevelt St, Bethesda, Md. 20817

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory Inc. — Date: Jan. 19 2001

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Irwin A Hoody

22. Name and Address of Facility: Rapp Funeral and Cremation Services, Stephen D. Lohrmann P.A., 933 Gist Ave., Silver Spring, Md. 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Bilateral Pneumonia — 1 Week

Due to (or as a consequence of):

b. Severe Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Artherosclerosis

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Albiol MD

29c. License number: D31319

29d. Date signed *(Month, Day, Year)*: January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Loreto S. Albiol, M.D. 8218 Wisconsin Ave. Bethesda, MD 20814

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

b

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6+1

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0253-031
LRB
JACOB ZIESE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23,& 27 per ME 030601 G793 SS

Certificate of Death

Reg. No. 2001 03478

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jason Carter Ziese
2. Date of Death: Month January Day 15, Year 2001
3. Time of Death: 8:02 A.M.
4a. Facility Name (If not Institution, give street and number): Shady Grove Adventist
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 212-92-4371
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 26 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Jan 14 1975
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9867 Brookeridge Court
10f. Zip Code: 20886
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Person
16b. Kind of Business/Industry: Retail Hobby Shop

17. Father's Name (First, Middle, Last): William C. Ziese
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Leach

19a. Informant's Name/Relationship (Type, Print): William C. Ziese/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4820 Creek Shore Drive, Rockville, MD 20852

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory Inc
Date: Jan 19 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ Kevin A. Hoody
22. Name and Address of Facility: Rapp Funeral & Cremation Services Stephen D. Lohrmann, PA 933 Gist Ave. Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDITIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Stephen S. Radentz, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 6

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-0154-033

HARRY

ZIRKLE amend item 28a-f per me G792 2/7/01 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03479

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRY LEE ZIRKLE,JR.

2. Date of Death (Month, Day, Year): JANUARY 9,2001

3. Time of Death: 6:29P.M.

4a. Facility Name (If not institution, give street and number): 1117 AYERS STREET

4b. City, Town, or Location of Death: ACCOKEEK

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 215-64-6326

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): NOV.22,1953

9. Birthplace (State or Foreign Country): WASHINGTON,DC

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGE

10c. City, Town or Location: ACCOKEEK

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1117 AYERS STREET

10f. Zip Code: 20607

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: ARMY 1978-81

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PAINTER

16b. Kind of Business/Industry: U.S.GOVT.

17. Father's Name (First, Middle, Last): HARRY LEE ZIRKLE,SR.

18. Mother's Nama (First, Middla, Maiden Surname): MARY RENCHER

19a. Informant's Name/Retationship (Type, Print): MARY RENCHER-MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): SAME AS #10

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY

Date: 1-11-01

20c. Location - City or Town, State: ALEXANDRIA,VA.

21. Signeture of Funeral Service Licensee: Michael O. Raymond M00479

22. Name and Addresa of Facility: RAYMOND FUNERAL SERVICE,P.A. LA PLATA,MARYLAND 20646

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hanging

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was casa rafarred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE

27. Mannar of Death: 1 [ ] Natural 2 [ ] Accident 3 [✓] Suicide 4 [ ] Homicide 5 [ ] Panding investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): found 1/9/01

28b. Time of Injury: found 6:21 P M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: subject hanged himself

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 1117 Ayers Street Accokeek, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be axcuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and ptace, and dua to the cause(a) and manner stated.

29b. Signature and title of certifier: Dennis Chutens

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 10,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chutens 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001

32. Registar's Signature: Benna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 031 80

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Mark Austin, Sr.

2. Date of Death Month Day Year: FEBRUARY 5, 2001

3. Time of Death: 5:19PM

4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-32-7510

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT. 2, 1921

9. Birthplace *(State or Foreign Country)*: Phillipines

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 600 Light Street, Apt. 722

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Shipping Supervisor

16b. Kind of Business/Industry: Hecht Company

17. Father's Name *(First, Middle, Last)*: Rubin Melvin Austin

18. Mother's Name *(First, Middle, Maiden Surname)*: Adalim Delapaz

19a. Informant's Name/Relationship *(Type, Print)*: Melvyn Auston - son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7011 Falls Reach Drive, Falls Church, Va. 22043

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Meadowridge Memorial Pk.

Date: 2/9/01

20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: Gary L. Kaufman

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. End Stage Liver Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* STELLA MARIS AT MEAD HOSPICE

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) and menner stated.

29b. Signeture end title of certifier: Dr. Myron

29c. License number: D40854

29d. Date signed *(Month, Day, Year)*: FEBRUARY 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 ST PAUL PL BALTIMORE MD 21202

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 08 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03481

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM U. ANDERSON
2. Date of Death: Month 02 Day 04 Year 2001
3. Time of Death: 1:58 P.M.
4a. Facility Name (If not institution, give street and number): Heritage Nursing Home
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 232.22.4443
6. Sex: 1 ☐ M 2 ☐ F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01.08. 1921
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2684 Wilkens Ave.
10f. Zip Code: 21223
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Bethlehem Steel.

17. Father's Name (First, Middle, Last): William Anderson
18. Mother's Name (First, Middle, Malden Surname): Nellie Wagner

19a. Informant's Name/Relationship (Type, Print): Ira Anderson - Son
19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 356 Reeves Dr. Wellsburg, WV 26070

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removet from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery — Date: 2/8/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ M&T. Marshall
22. Name end Address of Facility: Gary L. Kaufman Fun'l Hm. Inc. @ MeadowRidge Mem. Pk. 7250 Washington Blvd. Elkridge, MD 21075

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Finel disease or condition resulting in death)
e. CIRRHOSIS OF LIVER
Due to (or as a consequence of):
b. ASCITES
Due to (or as a consequence of):
c. ATRIAL FIBRILLATION
Due to (or as a consequence of):
d. OESOPHAGEAL VARICES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other stgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings availeble prior to completion of cause ot death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☑ No

26. Place of Deeth (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, and due to the cause(s) and manner as stated. 2 ☐ **Medicat Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Satinder K Tuteja MD
29c. License number: D27188
29d. Dete signed (Month, Day, Year): 2/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Satinder K Tuteja 2 Market Place Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): FEB 08 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03482

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frances Bevans

2. Date of Death Month / Day / Year: 02 / 06 / 01

3. Time of Death: 9:50 A.M.

4a. Facility Name *(If not institution, give street and number)*: Genesis ElderCare Homewood Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 218-22-6426

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 24, 1924

9. Birthplace *(State or Foreign Country)*: TENN.

Usual Residence of Decedent

10a. State: Md. | 10b. County: N/A | 10c. City, Town or Location: BALTIMORE | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2845 MULBERRY ST. | 10f. Zip Code: 21223 | 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CROSSING GUARD

16b. Kind of Business/Industry: CITY OF BALTIMORE

17. Father's Name *(First, Middle, Last)*: BROWNELL CARPENTER

18. Mother's Name *(First, Middle, Maiden Surname)*: Ida Mae Faw

19a. Informant's Name/Relationship *(Type, Print)*: BERNARD M. BEVANS/SPOUSE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2845 W. MULBERRY ST. BALTO, MD. 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GARRISON FOREST VA. CEM | Date: 2/13/01

20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: Steven A. Comanter

22. Name and Address of Facility: BETTS FUNERAL HOME 1639 N. CAROLINE ST. BALTO, MD. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — hours

Due to (or as a consequence of):
b. Hypertensive Cardiovascular Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. — Due to (or as a consequence of):
d. —

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Stroke

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attendant

29c. License number: D17118

29d. Date signed *(Month, Day, Year)*: Feb 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz MD. 7700 York Rd 21204

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 08 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

8

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03483

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VIVIENNE KATHLYN BEEBE
2. Date of Death (Month, Day, Year): FEBRUARY 4, 2001
3. Time of Death: 8:20 AM
4a. Facility Name *(If not institution, give street and number)*: MARINER HEALTH AT NORTH ARUNDEL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 524-01-5498
6. Sex: 1 ☐ M 2 ☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 20, 1917
9. Birthplace *(State or Foreign Country)*: IOWA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 297 ROESLER AVE.
10f. Zip Code: 21061
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: OPERATOR
16b. Kind of Business/Industry: COMMUNICATIONS

17. Father's Name *(First, Middle, Last)*: GEORGE D. OWEN
18. Mother's Name *(First, Middle, Maiden Surname)*: HAZEL MARY CUSHING

19a. Informant's Name/Relationship *(Type, Print)*: JOHN ROBINETTE/GUARDIAN
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 297 ROESLER AVE. GLEN BURNIE, MD 21061

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GLEN HAVEN MEM. PK. Date: FEB 7, 2001
20c. Location - City or Town, State: GLEN BURNIE, MD
21. Signature of Funeral Service Licensee: Paul L Ebaugh
22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 1 Week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Multi Infarct Dementia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Whyman MD Attending Doctor
29c. License number: D 21684
29d. Date signed *(Month, Day, Year)*: 2-6-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C.V. CYRIAC M.D 8021 RITCHIE HWY, PASADENA, MD 21122

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 08 2001
32. Registrar's Signature: Deputy G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #4 /PER D.V.R. G792 2-8-01 WR.

Certificate of Death

Reg. No. 2001 03484

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Doris C. Bowen

2. Date of Death — Month: February; Day: 1; Year: 2001

3. Time of Death: 1:30 pm

4a. Facility Name *(If not institution, give street and number)*: Stella Maris

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-10-9902

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 7/22/1918

9. Birthplace *(State or Foreign Country)*: Baltimore, MD

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Forest Hill

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2308 Warfield Drive

10f. Zip Code: 21050

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 years; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Senior Bank Teller

16b. Kind of Business/Industry: Equitable Trust Bank

17. Father's Name *(First, Middle, Last)*: Michael Bucsurics

18. Mother's Name *(First, Middle, Maiden Surname)*: Kristina (Unknown)

19a. Informant's Name/Relationship *(Type, Print)*: Gary Boyce

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2308 Warfield Drive Forest Hill, Md 21050

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore Cemetery — Date: 2/3/2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: E. F. Lassahn

22. Name and Address of Facility: E.F.Lassahn Funeral Home 11750 Belair Rd Kingsville, MD 21087

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only* one cause *on* each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular 0/155-12

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 15504

29d. Date signed *(Month, Day, Year)*: 02 01 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EDDIE NAKHUDA STELLA MARIS TIMONIUM, MD.

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 08 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

NAME: BOWEN, DORIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03485

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
LANESE	D.	CHASE	February	03	2001	1545

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-86-2461	1☐ M 2☑ F	30 Yrs.					Nov. 1, 1970	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Owings Mills	1☐ Yes 2☑ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10225 Jensen Lane	21117	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☑ No If Yes, Give Year or Dates:	1☐ Yes 2☑ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2yrs.	Home Improvement	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Chase	Betty Lancaster

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Frances Cornitcher-Sister	9657 Basket Ring Rd. Apt. 4 Columbia, MD. 21045

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Mt. Zion Cemetery	2-10-01	Lansdowne, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Gary P. March Funeral Home P.A. 270 Fredhilton Pass Baltimore, MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Adult Respiratory Distress Syndrome	1 day
	Due to (or as a consequence of):	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last	b. SEPSIS	2 days
	Due to (or as e consequenca of):	
	c. Human Immunodeficiency Virus Infection	3-4 years
	Due to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Hepatitis C Infection

GastroIntestinal bleed

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☐ Yes 2☒ No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Ardehali, MD, PhD	RES-000	02/03/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HOSSEIN ARDEHALI, MD, PhD, Johns Hopkins Hospital, Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 07 2001	▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03486

CRANFORD, IRENE

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IRENE CRANFORD

2. Date of Death (Month, Day, Year): FEBRUARY 4, 2001

3. Time of Death: 6:40 P.M.

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 233-38-8002

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 27 1926

9. Birthplace (State or Foreign Country): WestVirginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2234 Redthorn Road

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled

16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last): Burs Geogeline

18. Mother's Name (First, Middle, Maiden Surname): Ann Pingwald

19a. Informant's Name/Relationship (Type, Print): Hoyt G. Cranford / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P,O,Box 566 Hedgeville West Virginia 25427

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro CRematory Inc.

Date:

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 MAce AVe. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMATOSIS — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. NON SMALL CELL Carcinoma of LUNG

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 22a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N Gauhar

29c. License number: D 18326

29d. Date signed (Month, Day, Year): 2/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NAEEM GAUHAR, Essex Med Ctr, Baltimore MD 21221

State Registrar

31. Date filed (Month, Day, Year): FEB 08 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03487

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Costa

2. Date of Death (Month, Day, Year): FEBRUARY 5, 2001

3. Time of Death: 3:41 PM

4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 161-05-7700

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5/4/1920

9. Birthplace (State or Foreign Country): Phila. PA

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 704 Ferguson Road

10f. Zip Code: 21085

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hairdresser

16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Salvator DiGiovanni

18. Mother's Name (First, Middle, Maiden Surname): Pasqualina Regina

19a. Informant's Name/Relationship (Type, Print): Santa Marie Gunn (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1026 Heaps Rd. Street, Md 21154

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens

Date: 2/10/01

20c. Location - City or Town, Stete: Timonium, MD

21. Signature of Funerel Service Licensee: E.F. Lassahn

22. Neme end Address of Facility: E.F.Lassahn Funeral Home 11750 Belair Rd Kingsville, MD 21087

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

a. CORONARY ARTERY DISEASE, STATUS POST — 30Minute

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last

b. CORONARY ARTERY BYPASS SURGERY AND

Due to (or as e consequence of):

c. AORTIC VALVE REPLACEMENT

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and menner stated.

29b. Signature and title of certifier: David A. Brinker MD.

29c. License number: D 0051852

29d. Dete signed (Month, Day, Year): 2/6/2001

30. Name and address of person who completed cause of death (Item 23a) (Typa, Print): DAVID A. BRINKER, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Dete filed (Month, Day, Year): FEB 08 2001

32. Registrer's Signeture: Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03488

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ardys Wilbur Carson	February 6, 2001	9:30 am M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Clearview Nursing Home	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
208-28-6960	1☒M 2☐F	87 Yrs.			October 9, 1913	PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
PA	Fulton	Warfordsburg	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
2081 McKibbin Lane	17267	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Farmer	Agriculture

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Carson	Cordelia Smith

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cordelia J.Carson/Daughter	P.O.Box 1093 Hagerstown, MD 21741

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Amaranth Brethren	02/09/2001	Warfordsburg, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Grove Funeral Home, P.A. 141 W.Main St.Hancock,MD 21750-0368

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Bronchopneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic Cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Dey Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, Hypertension

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No 3☐Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☐Residence 8☐Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dale end place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D 02857	2/06/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Edson B. Moody 1190 Mt.Aetna RD Hagerstown, MD 21740

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 08 2001	[signature] G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03489

CALDWELL, CHRISTINE 2/5/01 3:25PM

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
CHRISTINE PATRICIA CALDWELL	February 5, 2001	3:25 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-22-5529	1☐ M 2☒ F	73 Yrs.			Oct. 24, 1927	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Parkville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8820 Walther Blvd. apt.1413	21234	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2 years	Contracts Administrator	Government Health & Human Services

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Logan	Grace Gertrude Cassell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Donald Caldwell (husband)	8820 Walther Blvd. apt.1413 Parkville, Maryland 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Dulaney Valley Memorial Gardens	2-8-01	Timonium, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
George J. Ferrante	Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. RESTRICTIVE CARDIOMYOPATHY	YEARS
Due to (or as e consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. AMYLOIDOSIS	YEARS
Due to (or as a consequence of):		
	c. MULTIPLE MYELOMA	YEARS
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal failure, thrombocytopenia, pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Patricia Savadel, MD	D27209	2/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PATRICIA A. SAVADEL, M.D. 1205 YORK RD. SUITE 18 LUTHERVILLE, MD 21093

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 08 2001	Geneva D. Sparks

Division of Vital Records, P.O. Box 68760,

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03490

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna L. Donaldson
2. Date of Death (Month, Day, Year): February 3, 2001
3. Time of Death: 11:10 PM
4a. Facility Name (If not institution, give street and number): St Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 219-38-6237
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-10-1919
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: Md
10b. County: Balto
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8418 Governers Run
10f. Zip Code: 21043
10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Crossing Guard
16b. Kind of Business/Industry: Baltimore City Police Department

17. Father's Name (First, Middle, Last): George Witherspoon
18. Mother's Name (First, Middle, Maiden Surname): Florence Borders

19a. Informant's Name/Relationship (Type, Print): Ernest W. Donaldson Jr-Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8418 Governers Run Ellicott city, Md 21043

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley
Date: 2-9-01
20c. Location - City or Town, State: Timonium, Md

21. Signature of Funeral Service Licensee: Glynn B Keke
22. Name and Address of Facility: March F. H. West 4300 Wabash Avenue Balto, Md 21215

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — Weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebral Vascular Accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attending Physician
29c. License number: D51853
29d. Date signed (Month, Day, Year): February 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Silverman, MD 900 Caton Avenue Baltimore 21229

State Registrar

31. Date filed (Month, Day, Year): FEB 08 2001
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Donaldson, Anna L.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03491

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LIONIEL DOTSON

2. Date of Death (Month, Day, Year): FEBRUARY 3, 2001

3. Time of Death: 11:59 PM

4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-28-7757

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 2-17-1935

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5532 NOME AVE.

10f. Zip Code: 21215

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): -12- / College (1-4or 5+): -0-

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER

16b. Kind of Business/Industry: COLA COMPANY

17. Father's Name *(First, Middle, Last)*: JOHN GOUGH

18. Mother's Name *(First, Middle, Maiden Surname)*: CECILIA DOTSON

19a. Informant's Name/Relationship *(Type, Print)*: PEARL L. DOTSON(WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5532 NOME AVE. BALTIMORE, MARYLAND 21215

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other *(Specify)* ENTOMBMENT

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARBUTUS MEMORIAL PARK

Date: 2-9-2001

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Vernon L. Bailey

22. Name and Address of Facility: VERNON BAILEY FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. INTRACEREBRAL HEMORRHAGE — 48 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: GASTROINTESTINAL HEMORRHAGE; GASTRIC CARCINOMA WITH METASTASIS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E. Layug M.D.

29c. License number: D 24025

29d. Date signed *(Month, Day, Year)*: 02/04/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EDUARDO P. LAYUG, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 0 8 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

RJD
UNK#-01-018
01-351-005

MICHAEL DAVIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03492

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MICHAEL PASFIELD DAVIS

2. Date of Death Month Day Year: JANUARY 21, 2001

3. Time of Death: 2130 P.M.

4a. Facility Name *(If not institution, give street and number)*: 525 WINDWOOD RD.

4b. City, Town, or Location of Death: Anneslie

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-70-9947

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 41 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 22, 1959

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Anneslie

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 525Windwood Road

10f. Zip Code: 21212

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementery/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Technician

16b. Kind of Business/Industry: Computers

17. Fathar's Nama *(First, Middle, Last)*: James Otis Davis, Jr.

18. Mothar's Name *(First, Middle, Meiden Sumame)*: Joan Pasfield Davis

19a. Informent's Neme/Relationship *(Type, Print)*: William H. Pasfield

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 3076 Riverside Drive, Wanthagh, NY 11793

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Nama of cemetery, cremetory or othar piece)*: Green Mount Cemetery

Date: 2/7/2001

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson

22. Name end Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc, 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that causad tha daath. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in deeth)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or es e consequenca of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [✓] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [XX] Other *(Specify)* SCENE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred

28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner steted.

29b. Signeture end title of certifier: J Pestaner M.D.

29c. License number: O.C.M.E.

29d. Dete signed *(Month, Dey, Year)*: JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 08 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 031493

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GENEVA EDWARDS

2. Date of Death Month: FEBRUARY Day: 7 Year: 2001

3. Time of Death: 1135

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSP 5601 LOCH RAVEN BLVD

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-20-9869

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07-07-1923

9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 3225 LYNDALE AVE

10f. Zip Code: 21213

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC

16b. Kind of Business/Industry: HOUSEKEEPING

17. Father's Name (First, Middle, Last): ZACK STEVENSON

18. Mother's Name (First, Middle, Maiden Surname): MINNIE SMITH

19a. Informant's Name/Relationship (Type, Print): MARION THOMAS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3406 ROYCE AVE, BALTIMORE, MD 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): DULANEY VALLEY

Date: 02-12-01

20c. Location - City or Town, State: DULANEY VALLEY

21. Signature of Funeral Service Licensee: ▶ Willie E. Howell Jr

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. METASTATIC LUNG CANCER

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] DO

29c. License number: P14413

29d. Date signed (Month, Day, Year): FEBRUARY 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOAN CHANG, DO 5601 LOCH RAVEN BLVD, BALTIMORE, MARYLAND

State Registrar

31. Date filed (Month, Day, Year): FEB 08 2001

32. Registrar's Signature: ▶ [signature]

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 03494

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Curtis, W, Enzenga	02 05 2001	7:50 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland	Baltimore	Baltimore city

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-76-1305	1☒M 2☐F	32 Yrs.			Aug. 12, 1968	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Glen Burnie	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1707 Manning Road	21061	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Construction	Elevator Repair

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Philip J. Enzenga	Unknown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Philip Enzenga/Father	1707 Manning Road Glen Burnie, MD 21061

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory	Feb. 8, 2001	Catonsville, MD

21. Signature of Funeral Service Licensee: Paul L Boarman

22. Name and Address of Facility: Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Anoxic Brain Injury	
	Due to (or as a consequence of):	
	b. Respiratory failure	1 month
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD.	RES 000	2/5/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Michael Rodrigues, MD University of Maryland Department of Surgery 22 South Greene St. 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 08 2001	B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0592-005
DEXA S. EVANS
ASP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03495

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DEXA HUNT STRADLING EVANS

2. Date of Death: Month FEBRUARY Day 03 Year 2001

3. Time of Death: 0533 M

4a. Facility Name *(If not institution, give street and number)*: NORTHWEST HOSPITAL

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 100-28-8418

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov 3, 1935

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 17 E. Burke Avenue

10f. Zip Code: 21204

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 2+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

18b. Kind of Business/Industry: Legal

17. Father's Name *(First, Middle, Last)*: Frederick Stradling

18. Mother's Name *(First, Middle, Maiden Surname)*: Bessie Evans

19a. Informant's Name/Relationship *(Type, Print)*: Brooke Alison Evans (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17 Merriewood Lane, N; Monroe, NY 10950

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Green Mount Cemetery Date: 2/7/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Martin D. Dawson

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Alan Locke, MD

29c. License number: O.C.M.E

29d. Date signed *(Month, Day, Year)*: FEBRUARY 04, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Alan Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 08 2001

32. Registrar's Signature: Jennie B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03496

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Monda Eastlake

2. Date of Death: Month Febuary Day 5 Year 2001

3. Time of Death: 248 pm

4a Facility Name (If not institution, give street and number): Univ. of Maryland Greenbaum Cancer Center

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 214-56-1958

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): JULY 29, 1950

9. Birthplace (State or Foreign Country): N. CAROLINA

Usual Residance of Decedent

10a. State: MD

10b. County: ANNE ARUNDEL

10c. City, Town or Location: MILLERSVILLE

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 459 MARTIN DRIVE

10f. Zip Code: 21108

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: WHITE

15. Decedent's Education (Specify only highast grada completed): Elemantary/Secondary (0-12): 12 Collega (1-4or 5+): 2

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): SELF EMPLOYED

16b. Kind of Businass/Industry: CHILD CARE

17. Fathar's Nama (First, Middla, Last): ADOLPHUS WEBB

18. Mothar's Nama (First, Middla, Maiden Surnama): MARGIE (FULLER)

19e. Informant's Name/Reletionship (Type, Print): JAMES WILEY (SON)

19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1726 CHURCHVILLE ROAD CHURCHVILLE, MD 21015

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematery, cramatory or othar place): METRO CREMATORY

Data: 2/8/01

20c. Location - City or Town, Stata: CATONSVILLE, MD

21. Signature of Funeral Service Licensee:

22. Nama and Address of Facility: CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart tailure. List only ona ceuse on eech line.

		Approximata Intarval Between Onsat and Death
Immediata Causa (Final disaasa or condition resulting in daath) a.	Fungal Sepsis	1 week
Due to (or as e consequence of): b.	Bacterial Sepsis	2 weeks
Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last — Due to (or as a consequence of): c.	Acute Myelogenous Leukemia	10 months
d.		

Part II. **Other significant conditions** contributing to death but not rasulting in tha undertying causa givan in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wera autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Place of Death (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding invastigetion 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29e. Certifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifiar: MD

29c. License number: P13417

29d. Date signed (Month, Day, Year): Febuary 5, 2001

30. Nama and address of parson who completed causa of daath (Item 23a) (Type, Print): Stephen Summers University of Maryland 22 South Greene Street, Baltimore MD 21201

State Registrar

31. Data filed (Month, Day, Year): FEB 08 2001

32. Registrar's Signature: J. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03497

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM RATH GILROY

2. Date of Death: Month FEB Day 06 Year 2001

3. Time of Death: 315 AM

4a. Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-03-2644

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 20, 1910

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 715 MAIDEN CHOICE LANE, APT. CC601

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes: 1942-1943

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): FUNERAL DIRECTOR

16b. Kind of Business/Industry: DEATH CARE

17. Father's Neme (First, Middle, Last): JOHN WESLEY GILROY

18. Mother's Neme (First, Middle, Maiden Surneme): LOUISE RATH

19a. Informent's Neme/Reletionship (Type, Print): (SON) REV. DR. WILLIAM F.R. GILROY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6224 MEDORA ROAD, LINTHICUM, MD. 21090

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremation 3 [ ] Removel from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): CHESAPEAKE CREMATION CENTER, LLC. Date: 2/7/01

20c. Location - City or Town, State: STEVENSVILLE, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Feciility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: DAYS-MTHS.

Immediate Cause (Final disease or condition resulting in death): a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: P144415

29d. Date signed (Month, Day, Year): Feb/6/01

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): MATTISH PANDYA, ST AGNES HEALTHCARE, 900 CATONAVE, BALTIMORE, MD-21229.

State Registrar

31. Dete filed (Month, Dey, Year): FEB 08 2001

32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME WILLIAM R GILROY

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 03498

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLORENCE GREBE

2. Date of Death: Month FEBRUARY Day 4 Year 2001

3. Time of Death: 5:55 AM

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 212-09-7472

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 22 1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 26 Clipper Road

10f. Zip Code: 21221

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Christian Karl Gutermuth

18. Mother's Name (First, Middle, Maiden Surname): Ernestine Keller

19a. Informant's Name/Relationship (Type, Print): Edward Gutermuth /brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Lombardy Drive Baltimore Md. 21222

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak LAwn Cemetery

Date: 2/7/2001

20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace AVe. Baltimore MD 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS — Approximate Interval Between Onset and Death: 24 HOURS

Due to (or as a consequence of):

b. OSTEOMYELITIS — 3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. GASTROINTESTINAL BLEED — UNKNOWN

Due to (or as a consequence of):

d. ACUTE RENAL FAILURE — 2 WEEKS

If FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

STAGE III SACRAL DECUBITUS

HYPERTENSION

CORONARY ARTERY DISEASE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Resident Physician

29c. License number: D0056497

29d. Date signed (Month, Day, Year): FEBRUARY, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MATTHEW OLNES MD 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

State Registrar

31. Date filed (Month, Day, Year): FEB 08 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification;

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03499

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET E GERWIG
2. Date of Death Month: Feb Day: 5 Year: 2001
3. Time of Death: 12:05pm
4a. Facility Name *(If not institution, give street and number)*: 1269 Damsel Road
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-12-2879
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb.3 1922
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1269 DAmsel Road
10f. Zip Code: 21221
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Bleck, White, etc. *Specify:* White
15. Decedent's Edcetion *(Specify only highest grede completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 1yr
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Practical Nurse
16b. Kind of Business/Industry: Doctor's Office
17. Fether's Neme *(First, Middle, Last)*: William Luby
18. Mother's Neme *(First, Middle, Maiden Surname)*: Sophia Bolling
19a. Intorment's Neme/Reletionship *(Type, Print)*: Andrew Gerwig / son
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 724 Greendale Road York PA 17043
20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: Holly Hill Cemetery
Dete: 2/8/2001
20c. Location - City or Town, Stete: Baltimore MD
21. Signeture of Funerel Service Licensee: R. Terry Connelly
22. Name end Address of Fecility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md 21221

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in death)
a. METASTATIC CARCINOMA OF THE BRAIN — 2 MOS.

Due to (or as a consequence of):
b. NON-SMALL CELL CARCINOMA OF THE LUNG — 8 MOS.

Sequentially list conditions, If any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest

Due to (or as a consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, and due to tha ceuse(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: M.D.
29c. License number: D17728
29d. Date signed *(Month, Day, Year)*: 2/7/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Ba Yin Oung, M.D. 8022 Belair Rd. Balto., MD 21236

State Registrar

31. Dete filed *(Month, Dey, Year)*: FEB 08 2001
32. Registrers Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03500

Guyton, Lucille

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucille N. Guyton

2. Date of Death (Month, Day, Year): February 3 2001

3. Time of Death: 6 40 Am

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 215-03-5083

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11 09 14

9. Birthplace (State or Foreign Country): I.N.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 701 North Arlington Ave Apt 104

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Presser

16b. Kind of Business/Industry: Laundry Mat

17. Father's Name (First, Middle, Last): Rev. John Saunders

18. Mother's Name (First, Middle, Maiden Surname): Margaret Moore

19a. Informant's Name/Ratationship (Type, Print): Rev. Julia Wise-Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 117 North Kossuth Street, Baltimore Md 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Druid Ridge Cemetery

Data: 2/8/01

20c. Location - City or Town, State: Pikesville, Md

21. Signature of Funeral Service Licensee: Lola March

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore, Md 21215

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. COPD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Liver Failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Myocardial Infarction

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John A Mutter, III MD

29c. License number: RES 000

29d. Date signed (Month, Day, Year): February 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sinai Hospital of Baltimore, John A Mutter, III MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): FEB 08 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL